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In the Supreme Court of the United States

OCTOBER TERM, 1986

OTIS R. BOWEN, SECRETARY OF HEALTH AND HUMAN SERVICES, PETITIONER

v.

STANLEY CUBANSKI, DIRECTOR OF THE CALIFORNIA DEPARTMENT OF HEALTH SERVICES, ET AL.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

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QUESTIONS PRESENTED

1. Whether language in an internal agency manual prepared for use by field employees is a "legislative regulation" that binds the Secretary of Health and Human Services, even though it was never subjected to notice-and-comment rulemaking or published in the Federal Register, and even though it is contradicted by a regulation duly promulgated by the Secretary pursuant to the Administrative Procedure Act.

2. Whether Section 2373(c) of the Deficit Reduction Act of 1984 prohibits the Secretary of Health and Human Services from disapproving proposed amendments to state Medicaid plans that conflict with statutory limitations on federal financial participation in the Medicaid program.

PARTIES TO THE PROCEEDING

In addition to those named in the caption, the parties are: Donald A. Barrier, Alan Bierman, Lola Bierman, James Jones, and Ronald Kwiek, all of whom intervened in the administrative proceedings and in the court of appeals.

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PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

The Solicitor General, on behalf of the Secretary of Health and Human Services, petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Ninth Circuit in this case.

OPINIONS BELOW

The opinion of the court of appeals (App., *infra,* 1a-19a) is reported at 781 F.2d 1421. The opinion dissenting from the denial of rehearing en banc (App., *infra,* 23a-35a) is reported at 794 F.2d 540. The opinion of the Administrator of the Heath Care Financing Administration (App., *infra,* 38a-45a) is unreported.

JURISDICTION

The judgment of the court of appeals was entered on February 7, 1986 (App., *infra,* 21a). An order amending the panel opinion was entered on March 6, 1986 (App., *infra,* 20a). A petition for rehearing was denied on July 14,

1986 (App., *infra,* 22a). An opinion dissenting from the denial of rehearing en banc was filed on July 18, 1986 (App., *infra,* 23a-35a). On October 3, 1986, Justice O'Connor extended the time for filing a petition for a writ of certiorari to and including November 26, 1986. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

The relevant portions of Sections 1902(a) and 1903(f) of the Social Security Act, 42 U.S.C. 1396a(a) and 1396b(f), of Section 2373(c) of the Deficit Reduction Act of 1984, Pub. L. No. 98-369, 98 Stat. 494, of 42 C.F.R. 435.811 and 435.1007, and of Section 14005.12 of the California Welfare and Institutions Code, are set out at App., *infra* 46a-49a.

STATEMENT

1. Congress established the Medicaid program in 1965 "for the purpose of providing federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons." *Harris* v. *McRae,* 448 U.S. 297, 301 (1980); see *Atkins* v. *Rivera,* No. 86-632 (June 23, 1986), slip op. 2. Medicaid is a cooperative federal-state program employing both state and federal funds. See 42 U.S.C. 1396b. The decision whether to participate in Medicaid is left to the discretion of each state. Once a state elects to participate, it must comply with requirements imposed by the Medicaid Act and by the Secretary of Health and Human Services. See 42 U.S.C. (& Supp. II) 1396a; *Atkins* v. *Rivera,* slip op. 2; *Schweiker* v. *Gray Panthers,* 453 U.S. 34, 37 (1981). Upon obtaining the Secretary's approval of its Medicaid plan, a state is entitled to federal financial assistance for providing medical care to individuals who qualify under that plan. See 42 U.S.C. (& Supp. II) 1316(a), 1396, 1396a(b), 1396b(a).

Individuals covered by certain cash assistance programs—the Supplemental Security Income (SSI) Program, 42 U.S.C. 1381 *et seq.*, and the Aid to Families With Dependent Children (AFDC) Program, 42 U.S.C. 602 *et seq.*—automatically qualify for Medicaid. Thus, states that choose to participate in Medicaid are required to provide benefits to these persons, termed the "categorically needy." See 42 U.S.C. 1396a(a)(10)(A)(i); 42 C.F.R. 435.4, 433.110(a), 435.120(a); *Atkins* v. *Rivera,* slip op. 2; *Gray Panthers,* 453 U.S. at 37-39. In addition, and at its option, a participating state may provide Medicaid benefits to other "less needy" individuals. See H.R. Rep. 213, 89th Cong., 1st Sess. 66 (1965). In general, these are "medically needy" people who would qualify for SSI or AFDC except that their income and resources exceed the levels set for those categorical assistance programs. See *Atkins* v. *Rivera,* slip op. 3; *Schweiker* v. *Hogan,* 457 U.S. 569, 572-573 (1982). The "medically needy" qualify for Medicaid only if they incur medical expenses that reduce their income to the Medicaid eligibility income standard. See 42 U.S.C. 1396a(a)(17); 42 C.F.R. 435.831(c).

At the beginning of the Medicaid program, no limit was placed on the amount of federal reimbursement to the states for optional coverage given the "medically needy." In 1967, however, Congress determined that a limit on federal participation was desirable to guard against improvident Medicaid spending by the states. See *Hogan,* 457 U.S. at 573, 576. Accordingly, Congress enacted legislation to ensure that "federal sharing * * * not be available for families whose income exceeds 133⅓ percent of the highest amount ordinarily paid to a family of the same size * * * in the form of money payments under the AFDC program." H.R. Rep. 544, 90th Cong., 1st Sess. 117, 119 (1967). To effect that congressional purpose, Section 1903(f)(1)(B)(i) of the Social Security Act, 42 U.S.C.

1396b(f)(1)(B)(i), provides that federal financial participation is limited as follows:

> the applicable income limitation with respect to any family is the amount determined, in accordance with standards prescribed by the Secretary, to be equivalent to 133⅓ percent of the highest amount which would ordinarily be paid to a family of the same size without any income or resources, in the form of money payments, under the [AFDC] plan of the [relevant] State * * *.

The Secretary issued regulations in 1971 pursuant to this directive. 36 Fed. Reg. 3871-3872. Those regulations, now codified at 42 C.F.R. 435.1007, reiterate the statutory requirement that Medicaid benefits bear a fixed mathematical relationship to the AFDC benefits that would be paid to "a family of the same size." The regulations provide that, for couples and families of two or more, federal financial participation is available only when the state's Medicaid eligibility level does not exceed "133⅓ percent of the highest money payment that would ordinarily be made under the State's AFDC plan to a family of the same size without income and resources." 42 C.F.R. 435.1007(a)(1). See also 42 C.F.R. 435.811(c).[1]

2. Respondent Cubanski is the Director of the California Department of Health Services. In September 1983, California proposed to amend its Medicaid plan to provide more generous benefits. Specifically, California proposed to revise upward its "medically needy income level"

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[1] The regulations promulgated in 1971 were initially codified at 45 C.F.R. 248.21(b)(2) and (3) (1972 ed.). They were recodified in 1974 at 45 C.F.R. 248.4(b)(4) (1974) and again in 1978 at 42 C.F.R. 448.4(b)(4). In September 1978, the regulations were amended to their present form and recodified at 42 C.F.R. 435.1007. The language at issue in this case ("family of the same size") has not undergone substantive change since the initial regulations were issued in 1971.

(MNIL), which is the maximum amount of income that a medically needy individual or family may keep for nonmedical needs and still be eligible for Medicaid.[2] Under the State's proposed amendment, the monthly MNIL for a family consisting of *two* adults would be 133⅓ percent of "the highest amount that would ordinarily be paid to a family of *three* persons without income or resources under [the State's AFDC program]." Cal. Welf. & Inst. Code § 14005.12(c) (West Supp. 1986) (emphasis added).

In December 1983, the Health Care Financing Administration (HCFA), a subdivision of HHS, notified the State that its proposal was rejected because it did not comply with the statutory and regulatory requirement that Medicaid payments not exceed 133⅓ percent of the maximum AFDC payment "to a family of the same size" (42 U.S.C. 1396b(f)(1)(B)(i); 42 C.F.R. 435.1007(a)). On administrative appeal, that decision was ultimately upheld by the HFCA Administrator (App., *infra*, 38a-45a).

The State's principal argument throughout the administrative process was that its proposed amendment was supported by language that appeared in a HCFA regional office manual that was issued on June 30, 1979. In contrast to the regulation promulgated by the Secretary in

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[2] The effects of a change in the MNIL may be illustrated by a simplified example. Assume a "medically needy" individual with monthly "countable" income of $300 and monthly medical expenses of $150. If the state's MNIL is $200, that individual may retain $200 for nonmedical needs; Medicaid will pay for $50 of his medical expenses and he will be responsible for the $100 balance. Now assume that the state raises its MNIL to $250. That same individual would then keep $250 for nonmedical needs; Medicaid would cover $100 of his medical bills, and he would be responsible for only $50 per month. As this illustration shows, the higher the MNIL, the greater the proportion of medical expenses covered by Medicaid. Program costs further escalate with a higher MNIL because greater numbers of people qualify for benefits.

1971, as amended in 1978, which required that a state's Medicaid MNIL be no more than 133⅓ percent of the state's maximum AFDC payment for a family "of the same size," the field manual said (§ 2572D) that "the States may set a separate medically needy income level for two adults which would be established between 133-⅓% of the AFDC payment level for one person and 133-⅓% of the AFDC payment level for a family of three persons." The manual also said that states "should have the option of establishing separate medically needy income levels for a two-person family consisting of one adult and one child and for a two-person family composed of two adults" (*ibid.*). These sentences were deleted from a superseding edition of the manual issued in July 1980.

The HCFA Administrator rejected the State's contention. She concluded that "the statute provides for a single MNIL for a family of two" and that this limit is 133⅓ percent of the maximum payment ordinarily made under the State's AFDC plan "to a family of the same size without income and resources" (App., *infra*, 42a). The Administrator concluded that the Secretary's regulation, which likewise speaks of AFDC payments "to a family of the same size" (42 C.F.R. 435.1007), was "absolutely clear regarding a family of two" (App., *infra*, 42a). The Administrator found the language in the HCFA field manual to be "patently contrary to the statute and * * *, therefore, invalid from its origination," since "the Secretary is bound to follow the direction of Congress" (App., *infra*, 44a).[3]

3. On petition for review, the court of appeals reversed the agency's determination (App., *infra*, 1a-19a). The court concluded that the statutory directive limiting

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[3] The Administrator also rejected the State's alternative argument that Section 2373(c) of the Deficit Reduction Act of 1984 (DEFRA), Pub. L. No. 98-369, 98 Stat. 1112, prohibited the Secretary from disapproving the proposed amendment of the state plan.

federal financial participation to 133⅓% of the highest AFDC payment "to a family of the same size" was tempered by language requiring that this limit be determined "in accordance with standards prescribed by the Secretary." App., *infra,* 7a, citing 42 U.S.C. 1396b(f)(1)(B)(i). In the court's view, the 1979 office manual prescribed just such a "standard," and a state was therefore permitted to set its MNIL for two adults as high as "133⅓ percent of the AFDC payment level for a family of three persons." The manual, the court concluded, set forth "a proper legislative rule" because it is a "rule 'issued by an agency pursuant to statutory authority and . . . implements the statute' " (App., *infra,* 13a, quoting *Batterton* v. *Francis,* 432 U.S. 416, 425 n.9 (1977)).

Citing this Court's decision in *Schweiker* v. *Hansen,* 450 U.S. 785 (1981), the court of appeals acknowledged that "agency office manuals generally do not prescribe legislative rules with binding effect" (App., *infra,* 11a). But the court held that this case represented "an exception" to that principle, asserting that the office manual involved here was "not a field-level instructional guide" because it was supposedly "directed not at office-level agency employees and specific recipients but at states and a major category of recipients under state plans" (*ibid.*). The court said that the 1979 version of the HCFA regional manual "establishe[d] the right of states to increase their adult couple MNIL" and "establishe[d] a new MNIL maximum * * * and thereby 'effect[s] a change in existing law or policy' " (*ibid.,* quoting *Powderly* v. *Schweiker,* 704 F.2d 1092, 1098 (9th Cir. 1983)).

Although the language in the field manual had never been subject to notice-and-comment rulemaking, and although it had not been published in the Federal Register or the Code of Federal Regulations, the court of appeals held that the manual had been properly promulgated as a "legislative regulation." The court noted (App., *infra,* 13a)

that the notice-and-comment procedures of the Administrative Procedure Act (APA) are generally inapplicable to matters relating to public benefits (5 U.S.C. 553(a)(2)). Although the Secretary by formal notice (36 Fed. Reg. 2532 (1971)) has voluntarily imposed the full panoply of APA procedural requirements upon HHS in such matters, the court said that these were not " 'procedural requirements imposed by Congress' " and hence concluded that the absence of notice-and-comment proceedings did not deny the manual the force of law (App., *infra,* 14a, quoting *Chrysler Corp.* v. *Brown,* 441 U.S. 281, 303 (1979)). With respect to the requirement of the Freedom of Information Act (FOIA) that agency regulations be published in the Federal Register (5 U.S.C. 552(a)(1)(D)), the court concluded that the FOIA requirement attaches only where nonpublication would adversely affect a member of the public, a situation that the court found was not present here (App., *infra,* 15a). The court therefore held that the manual was a lawfully promulgated regulation, exempt from the notice-and-comment procedures of the APA and the FOIA. And the Court held as an alternative ground of decision that "the DEFRA moratorium" in any event barred the Secretary from disapproving the proposed amendment to California's Medicaid plan (App., *infra,* 16a-18a).

4. The Secretary's suggestion for rehearing en banc was denied, with Judges Kozinski, Sneed, Hall and Noonan dissenting (App., *infra,* 22a-35a). In the dissenters' view, "[t]he panel err[ed] in almost every respect" (*id.* at 26a). The dissent pointed out that the HCFA's regional office manual was "not a body of regulations," but rather was "an *office manual,* an internal directive from the agency's headquarters to its field offices" (App., *infra,* 26a (emphasis in original)). The manual's "foreward," the dissent observed, stated that it was "for the use of regional office employees only," that it was "not intended to stand

alone," and that it "should not be cited when addressing contractors, State agencies, providers, etc." (*id.* at 26a-27a). Thus, even if the manual were the only statement on the subject emanating from the government, the dissent concluded that the manual would not, under *Schweiker* v. *Hansen, supra,* constitute a "legislative regulation" with the force and effect of law.

The dissent went on to argue that this conclusion followed a fortiori here, since the Secretary had in fact promulgated valid regulations that "plainly conflict" with the manual section (App., *infra,* 29a). Instead of deferring to these regulations, which explicitly link Medicaid entitlement to AFDC families "of the same size," the panel "effectively read[] the regulations out of existence without any explanation or admission of the fact" (*id.* at 30a). By subordinating formally promulgated regulations to an internal agency publication, the panel opinion, in the dissent's view, "tears asunder [the] tenets of administrative law" (*id.* at 31a) and "create[s] uncertainty where stability is vital" (*id.* at 32a). Judge Kozinski expressed concern that the panel opinion "will cause no end of headaches for agency officials who will now have to guess which of their informal, unsigned internal guidelines will be found 'exceptional' enough to outrank regulations" (*ibid.*). And he pointed out that, even if the manual could be thought to be a "regulation," it would be invalid "because it violates the plain language of the statute" (*id.* at 30a).

The dissent also took issue with the panel's alternative holding based on the DEFRA moratorium. Relying in part on this Court's decision in *Atkins* v. *Rivera, supra,* the dissent pointed out that the DEFRA moratorium "has nothing at all to do with this case" since it was intended to restrict the Secretary's authority under a portion of the statute not involved here (App., *infra,* 34a). In Judge Kozinski's words, "[t]he two provisions have about as

much in common as apples and pineapples: They sound vaguely similar but they grow on entirely different statutory trees."

REASONS FOR GRANTING THE PETITION

The decision below elevates to the status of a binding regulation language in an internal agency manual that was never published in the Federal Register or the Code of Federal Regulations, that was never intended as an official agency pronouncement, and that is flatly inconsistent both with a validly promulgated regulation of the Department of Health and Human Services and with the plain language of the statute. The court of appeals' decision reaching this odd result directly conflicts with decisions of this Court and with settled principles of administrative law. See *Schweiker* v. *Hansen*, 450 U.S. 785 (1981); *Morton* v. *Ruiz*, 415 U.S. 199 (1974). If it is permitted to stand, the decision below will generate enormous confusion as government officials—and those subject to regulation—are left to guess which statutes and regulations will be subordinated to the views expressed in documents such as the manual at issue here.

The court of appeals' alternative holding is equally devoid of merit. By expanding the DEFRA moratorium far beyond Congress's intent, the decision below prevents the Secretary from ensuring that proposed amendments to state plans are consistent with all requirements of the Social Security Act. It substantially undermines federal fiscal control over the Medicaid program. The Department of Health and Human Services estimates that the particular plan amendment proposed by California in this case would increase federal Medicaid expenditures by $50 million annually.

1. We start with the language of the statute. Congress provided that a state's entitlement to federal fiscal participation in Medicaid is limited by reference to the state's

level of AFDC benefits paid "to a family of the same size" (42 U.S.C. 1396b(f)(1)(B)(i)). The House Report makes clear the intent that "[f]ederal sharing will not be available for families whose income exceeds 133⅓ percent of the highest amount ordinarily paid to a family of the same size * * * in the form of money payments under the AFDC program." See H.R. Rep. 544, 90th Cong., 1st Sess. 119 (1967); *Schweiker* v. *Hogan*, 457 U.S. at 577.

The Secretary has interpreted this provision in a way that is consistent with the plain language and evident purpose of the statute. To implement the Act's limitation of federal participation in Medicaid to 133⅓% of the AFDC benefit paid to a family of the "same size," the Secretary has prescribed by regulation that federal financial participation is available only when it does not exceed, for couples and families of two or more, "133⅓ percent of the highest money payment that would ordinarily be made under the State's AFDC plan to a family of the same size without income and resources" (42 C.F.R. 435.1007 (a)(1)). This regulation and its predecessors have been in force for more than 15 years. See 43 Fed. Reg. 45217 (1978); 36 Fed. Reg. 3871 (1971); note 1, *supra*. As this Court recently explained, regulations of this type are entitled to "legislative effect" (*Atkins* v. *Rivera*, slip op. 7):

> Because the Secretary's regulation is "supported by the plain language of the statute and is adopted pursuant to the explicit grant of rulemaking authority * * *, it is entitled to more than mere deference or weight." *Gray Panthers*, 453 U.S. at 44, quoting *Batterton* v. *Francis*, 432 U.S. at 426. Indeed, it is entitled to "legislative effect," *id.* at 425, and is controlling "unless [it] is arbitrary, capricious, or manifestly contrary to the statute," *Chevron U.S.A., Inc.* v. *National Resources Defense Council, Inc.*, 467 U.S. 837, 844 (1984).

2. In contrast to the statute and regulation, which both refer to families of "the same size," California's proposed plan amendment would calculate Medicaid benefits for a family of *two* by reference to the highest AFDC payments to a family of *three*. Recognizing that a family of three is not the "same size" as a family of two, the Secretary properly disapproved California's proposal. In overturning the Secretary's determination, the court of appeals relied on the Act's delegation of authority to the Secretary to prescribe standards for determining what amount is "equivalent to 133⅓ percent of the highest amount which would normally be paid to [an AFDC] family of the same size" (42 U.S.C. 1396b(f)). But this delegation of authority plainly does not grant the Secretary the latitude to conclude that a family of three is the same size as a family of two. The "standards" that the Secretary was directed to prescribe are those establishing the State's determination as to which of its AFDC payment levels for a family of a given size is the "highest" that would "ordinarily be paid" to a family of that size. Once such standards have been employed, one can then multiply that "highest amount" by 133⅓ percent to derive the maximum Medicaid MNIL the State may establish for a family "of the same size" (42 U.S.C. 1396b(f)).

If, as the court below ruled, the Secretary may prescribe standards that treat two as equal to three, then the statutory requirement of equivalence is a nullity. "Read in this fashion," Judge Kozinski aptly put it, "the statute provides no limits whatsoever on the Secretary's discretion and might as well say 'the Secretary may set the MNIL any way he pleases' " (App., *infra*, 31a).

3. Even if the Secretary were thought to have discretion to prescribe standards under which a family of two would be deemed to be "the same size" as a family of three, the court of appeals plainly erred in concluding that the Secretary had in fact prescribed a "standard" in the

guise of HCFA's regional office manual. The court ruled that language contained in the 1979 version of the manual, language which was never published in the Federal Register or subjected to normal rulemaking procedures, and which was in conflict with the statutory mandate, was a "legislative rule" that "establishe[d] the right of states to increase their adult couple MNIL" (App., *infra,* 11a).

It is well settled that "not all agency publications are of binding force" (*Lyng* v. *Payne,* No. 84-1948 (June 17, 1986), slip op. 11). Indeed, if agencies were bound by every pronouncement made on their behalf, there would be no reason for Congress to have codified notice-and-comment procedures in the Administrative Procedure Act. Agency manuals in particular are examples of agency pronouncements that lack the force and effect of law. *Schweiker* v. *Hansen,* 450 U.S. at 789; *United States* v. *Caceres,* 440 U.S. 741 (1979); *Sullivan* v. *United States,* 348 U.S. 170, 172-174 (1954); *American Farm Lines* v. *Black Ball Freight Service,* 397 U.S. 532 (1970). In *Hansen,* a Social Security claims representative incorrectly told a claimant that she did not qualify for statutory insurance benefits; he also failed to advise her that she should file a written application for benefits, although the Social Security Claims Manual instructed claims representatives to give such advice. In refusing to estop the government from enforcing a lawful condition on the receipt of benefits, this Court acknowledged that the claims representative failed to follow the procedures provided for in the Claims Manual. The Court held, however, that "the Claims Manual is not a regulation * * * [i]t has no legal force, and it does not bind the [Social Security Administration]." 450 U.S. at 789. The Claims Manual, rather than being a compilation of binding regulations, was considered to be only a "handbook for internal use by thousands of SSA employees * * *." *Ibid.*

The court of appeals concluded that this case justified an exception to the established rule because, in the panel's view, the HCFA manual was not directed to office-level agency employees, but instead to "states and a major category of recipients under state plans" (App., *infra,* 11a). But, as the dissent demonstrates (*id.* at 28a (emphasis omitted)), the panel's rationale "flies in the face of [the manual's] own description of itself," for the manual explicitly says that it "is for the use of regional office employees only and should not be cited when addressing contractors, State agencies, providers, etc." Quite plainly, the manual was by its terms not intended for use by anyone other than HCFA employees—the same use for which the manual involved in *Schweiker* v. *Hansen* was intended. The court of appeals failed to acknowledge the manual's expressly limited purpose. And the court failed to explain how the manual, despite its explicit disclaimer, could be regarded as "a legislative rule issued pursuant to statutory authority" (App., *infra,* 16a).

4. The court's holding that the manual provision is a "regulation" becomes even more difficult to fathom when the manual is measured against the requirements that must be met before any agency publication has the force and effect of law. Ordinarily, published agency rules must "have certain substantive characteristics" and "be the product of certain procedural requisites." *Chrysler Corp.* v. *Brown,* 441 U.S. at 301. These include the procedural limitations and protections prescribed by the APA.

The manual provision upon which the court of appeals relied was never published in either the Federal Register or the Code of Federal Regulations. That nonpublication serves as a bright beacon showing that the agency did not regard the manual as its binding official interpretation. The United States Court of Appeals for the District of Columbia Circuit recently noted that an agency's "*[f]ailure* to publish in the Federal Register is [an] indication that the

statement in question was *not* meant to be a regulation," *Brock* v. *Cathedral Bluffs Shale Oil Co.*, 796 F.2d 533, 538 (1986) (emphasis in original). "The real dividing point" between regulations and agency statements that are not regulations, the court continued, "is publication in the Code of Federal Regulations, which the statute authorizes to contain only documents having general applicability *and legal effect*" (*id.* at 539 (emphasis in original)).

A further reason why the manual provision cannot be regarded as a regulation is that the provision was never the subject of notice-and-comment rulemaking. The court below suggested that notice-and-comment procedures were not applicable here because the manual provision concerns matters relating to public benefits (see 5 U.S.C. 553(a)(2)). But in 1971 the Secretary had voluntarily waived the "public benefits" exception by formally stating that departmental regulations would comply with the statutory procedural requirements. Quite apart from the question whether this voluntary waiver is "binding" on the Secretary to the same degree as procedural requirements imposed directly by Congress (see App., *infra*, 14a), the Secretary's decision not to subject the HCFA manual to notice-and-comment procedures plainly shows that *the Secretary* did not regard that manual as a "regulation." And it is no answer to infer, as did the court of appeals (*ibid.*), that the Secretary in issuing the manual simply "failed to abide by her predecessor's promise to adopt the APA rulemaking procedures," for that is to posit a presumption of agency *irregularity*.

Another reason why the manual provision cannot be regarded as a regulation is that the provision was never published in the Federal Register, as both the FOIA and the APA require. Unlike the APA, the FOIA has no "public benefits" exception and therefore plainly mandates that regulations must be issued by publication. The court of appeals asserted that FOIA's publication require-

ment attaches only where nonpublication " 'would adversely affect a member of the public' " and hence concluded that the HCFA manual, although unpublished, was nevertheless a valid "legislative rule." App., *infra,* 15a (quoting *Zaharakis* v. *Heckler,* 744 F.2d 711, 714 (9th Cir. 1984)). But putting to one side the question whether an agency's failure to publish a regulation in the Federal Register will invariably invalidate it, the Secretary's action in not publishing the manual here plainly shows that the Secretary did not regard it as a "regulation" at all, least of all a regulation effectively revoking prior regulations duly promulgated under the APA.[4]

Finally, even if the manual provision were deemed to be a "regulation," the judgment below would still be incorrect. The language of the manual is so inconsistent with the Social Security Act that, as the HCFA Administrator concluded, it was "invalid from its origination" (App., *infra,* 44a). The judges dissenting on rehearing agreed, stating that the manual "violates the plain language of the statute" (*id.* at 30a). For this reason, even if the language in the manual reflected the Secretary's interpretation and satisfied all procedural requirements of rulemaking, it could not lawfully be given effect. *Morton* v. *Ruiz,* 415 U.S. 199 (1974).

5. The decision below would warrant this Court's review if the court of appeals had done nothing more to thwart congressional intent than subordinate the plain language of the statute and the consistent interpretation of the Secretary to contradictory language in an internal agency document. By itself, that holding would wreak

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[4] The court's alchemy in turning into a regulation something that is immutably not a regulation is further undermined by two basic principles of administrative law. First, properly enacted regulations – such as 42 C.F.R. 435.811 and 435.1007 – are binding on the government until properly repealed. *United States ex rel. Accardi* v. *Shaughnessy,* 347 U.S. 260, 267 (1954). Second, "the government cannot supersede regulations by means of internal operating instructions." *Flores* v. *Bowen,* 790 F.2d 740 (9th Cir. 1986); see *Schweiker* v. *Hansen,* 450 U.S. at 789.

havoc on federal agencies and on the public by casting into doubt the certainty that federal rules and regulations are set forth in the Code of Federal Regulations and the Federal Register. Under the decision below, those official compilations of departmental rules would be subject to contradiction, revision, or repeal by far less formal and certainly less official pronouncements made by lower level employees. That is not the law. *Schweiker* v. *Hansen, supra; Heckler* v. *Community Health Services,* 467 U.S. 51, 63-65 (1984); *FCIC* v. *Merrill,* 332 U.S. 380, 384 (1947).

But the court of appeals did more than that. It held that anonymous, internal agency pronouncements retain "the force and effect of law" unless "repealed" or, possibly, until "removed from publication" (App., *infra,* 13a, 16a). The manual provision at issue in this case was deleted from the superseding HCFA regional manual issued in July 1980, three years before California proposed the instant plan amendment. Until the decision below, one would have thought that an agency's revision of its office manual would terminate whatever binding effect a predecessor version might be deemed to have. Apparently not. Although the government in its petition for rehearing (at 9 n.3) advised the court of appeals that the HCFA manual had been revised and the relevant language deleted in 1980, the panel took no cognizance of that fact. The court seems to have held, in other words, that the Secretary must engage in formal notice-and-comment rulemaking to *revise* an office manual, even though the manual's supposed status as a valid "legislative rule" rested on the court's antecedent conclusion that notice-and-comment rulemaking was not required when the manual was issued in the first place.

6. The panel also erred in overturning the Secretary's determination on the alternative ground that the Secretary was barred by Section 2373(c) of DEFRA from disapproving California's proposed plan amendment. DEFRA im-

posed a moratorium to preclude the Secretary from taking regulatory action against state Medicaid plans that might be inconsistent with the "single standard" or "same methodology" language that had been added to 42 U.S.C. 1396a(a)(10)(C)(i)(III) by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Pub. L. No. 97-248, § 137(b)(8), 96 Stat. 378.[5] As this Court recently explained, in the context of the "same methodology" provision, the TEFRA language deals with determining what resources are to be regarded as income for purposes of Medicaid eligibility. *Atkins* v. *Rivera,* slip op. 8.

This Court's opinion in *Atkins* makes it clear (slip op. 11) that the relevant TEFRA amendment was intended "solely to invalidate" certain post-1981 regulations "permitting the income and resources standards in state Medicaid plans to deviate from those used [in other welfare programs]." Congress later sought to stay the Secretary's hand in implementing the "same methodology" language and enacted the DEFRA moratorium for that purpose. In so doing, Congress reaffirmed that its sole intent was to override regulations the Secretary had issued following the Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, 95 Stat. 357 *et seq.* See H.R. Rep. 98-861, 98th Cong. 2d Sess. 1366-1368 (1984); *Atkins* v. *Rivera,* slip op. 12 n.10.[6]

The regulations at issue in this case were promulgated in 1978 (with predecessors dating back to 1971) and hence were not affected by TEFRA or the related DEFRA moratorium. Thus, the Secretary had no occasion to rely

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[5] That section requires a state to use the same methodology in determining eligibility for Medicaid as it would in determining eligibility for the categorically needy welfare programs and to use a single standard for determining income and resource eligibility for the medically needy.

[6] In contrast to the decision below, the Second Circuit, in another context, has correctly read the DEFRA moratorium in the circumscribed fashion of *Atkins* v. *Rivera.* See *Camacho* v. *Perales,* 786 F.2d 32, 42 (1986).

on the "single standard" or the "same methodology" provisions in disapproving California's proposed plan amendment. And, since the Secretary's action here was not an exercise of a power affected by the moratorium, the moratorium is totally irrelevant.

There is, ultimately, no conceivable reason why DEFRA, a deficit reduction measure, should be interpreted in a way that limits the Secretary's ability to enforce the statutory cap on federal financial participation in Medicaid. This case alone will result in a $50 million annual drain on the Treasury to fund one plan amendment in one state. A result so contrary to clearly expressed congressional intent should not be permitted to stand.[7]

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[7] The decision below has already had repercussions. The Secretary advises that at least one other state (Nebraska) has proposed to amend its plan in accordance with the California proposal in this case. In the Secretary's estimation, if the California amendment were adopted by all states participating in the Medicaid program, the added cost to the federal Treasury would be approximately $150 million. In addition, California has now proposed further plan amendments that would impose an additional burden on the federal fisc; under the court of appeals' holding on DEFRA, the Secretary may well be powerless to disapprove any of those proposals that are contrary to the statute.

Nor can the decision below be regarded as a sport. The Ninth Circuit has already relied on both alternative holdings in this case in a subsequent case in which it rejected the Secretary's implementation of a different portion of the Medicaid Act. *Vance* v. *Hegstrom*, 793 F.2d 1018 (1986).

CONCLUSION

The petition for a writ of certiorari should be granted.
Respectfully submitted.

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NOVEMBER 1986

APPENDIX A

UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

No. 85-7123

STANLEY CUBANSKI, DIRECTOR,
DEPARTMENT OF HEALTH SERVICES
STATE OF CALIFORNIA, PETITIONER,

AND

DONALD A. BARRIER, ALAN BIERMAN, LOLA BIERMAN,
JAMES JONES, RONALD KWIEK, PETITIONERS-INTERVENORS,

v.

MARGARET HECKLER, SECRETARY,
DEPARTMENT OF HEALTH AND HUMAN SERVICES,
UNITED STATES OF AMERICA, RESPONDENT.

Argued and Submitted
August 14, 1985—San Francisco, California

Filed February 7, 1986

Before: Ben C. Duniway and Herbert Y. C. Choy, Senior Circuit Judges, and Jerome Farris, Circuit Judge.

Opinion by Judge Duniway

Petition for Review of a Decision of the Department of Health and Human Services

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OPINION

DUNIWAY, Senior Circuit Judge:

The California legislature increased the amount of income a medically needy adult couple can keep for non-medical needs and still be eligible to receive Medicaid. The State submitted this amendment of its Medicaid plan to Health and Human Services (HHS) Secretary Heckler, who disapproved it. The California Department of Health Services (the State) and the Legal Aid Society of Alameda County (Intervenors) challenge the Secretary's final determination. We reverse.

I. *Facts.*

A. The Medicaid Program.

Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.*, was established "for the purpose of providing federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons." *Harris v. McRae*, 1980, 448 U.S. 297, 301. In order to participate in the program, States must submit a plan to the Secretary, who shall approve any plan which fulfills the requirements set out in 42 U.S.C. §1396a(a). 42 U.S.C.

§ 1396a(b). Upon such approval, the State becomes entitled to Federal Financial Participation in state expenditures made in accordance with that plan. 42 U.S.C. § 1396b.

A State Medicaid Program must provide medical assistance to so-called categorically needy recipients of welfare benefits. 42 U.S.C. § 1396a(a)(10)(A). In addition, states may provide Medicaid coverage to so-called medically needy aged, blind and disabled people and families whose income is too high to allow them to qualify for welfare benefits. 42 U.S.C. § 1396a(a)(10)(C).

Each state Medicaid plan must set an income standard for medically needy recipients in accordance with Federal requirements. This "medically needy income level" (MNIL) represents the amount of income an individual or family may keep for non-medical needs and still be eligible to receive Medicaid.

B. *Medi-Cal Revisions.*

The California Medicaid plan (Medi-Cal) includes medically needy recipients. Hearings conducted by the California legislature in early 1983 suggested that aged and disabled medically needy recipients were unable to afford necessary medically care, as well as non-medical necessities, under current income standards. In response to findings that elderly and disabled adults incur greater living expenses than families with dependent children, the California legislature amended its Medicaid plan to increase the MNIL for a family of two medically needy adults to the highest amount that would ordinarily be paid to a family of three persons without any income or resources under its aid to families with dependent children (AFDC) plan. Statutes of 1983, Ch. 323, § 124.6(c) (codified at Cal. Welfare and Inst. Code § 14005.12(c)). The effect of this amendment was to increase the MNIL for adult couples from $544 to $709 per month. Ch. 323

further directed the State Director of Health Services to adopt regulations to implement the amended provisions as emergency regulations "necessary for the immediate preservation of the public peace, health and safety, or general welfare," Section 124.7(d), and provided that the amended provision would be inapplicable to the extent that it conflicts with federal law, Section 124.7(a). The State began implementing these revisions on November 1, 1983, effective July 1, 1983.

C. *The Secretary's Determination.*

The State submitted State Plan Amendment (SPA) 83-14 to its Title XIX Medicaid Plan, reflecting its revised adult couple MNIL. On December 19, 1983, the Administrator of the Health Care Financing Administration (HCFA) notified the State that SPA 83-14 was disapproved on the ground that it violated Section 1903(f) of the Social Security Act, 42 U.S.C. § 1396b(f).

Pursuant to 42 U.S.C. § 1316(a), the State petitioned the Secretary to reconsider HFCA's disapproval of SPA 83-14. On November 30, 1984, after a hearing was held, the Hearing Officer issued a Recommended Decision that the HCFA decision should be affirmed. On January 30, 1985, the HCFA Administrator, pursuant to delegated authority from the Secretary, issued her final decision affirming her initial disapproval of the plan amendment.

The State filed a timely petition for review by this court of the Secretay's final decision pursuant to 42 U.S.C. § 1316(a)(3). On April 1, 1985, this court granted a Motion to Intervene filed by the Legal Aid Society of Alameda County on behalf of several medically needy adult couples.

II. *Standard of Review.*

In reviewing the Secretary's disapproval of SPA 83-14, this court must decide all relevant questions of law and in-

terpret the statutory provisions at issue. 5 U.S.C. § 706. The Secretary's decision must be set aside if found to be "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law," § 706(2)(A); "in excess of statutory . . . authority," § 706(2)(C); or "without observance of procedure required by law," § 706(2)(D). The Secretary's interpretation of the Medicaid Act is entitled to deference, *FEC v. Democratic Senatorial Campaign Committee*, 1981, 454 U.S. 27, 31-32. However, "the courts are the final authorities on issues of statutory construction. They must reject administrative constructions of the statute . . . that are inconsistent with the statutory mandate or that frustrate the policy that Congress sought to implement." *Id.* at 32. *See also Livermore v. Heckler*, 9 Cir., 1984, 743 F.2d 1396, 1404-1405.

III. Discussion.

A. Section 1903(f) and ROM § 2572-D.

Section 1903(f) of the Social Security Act, 42 U.S.C. § 1396b(f), states the limitation on Federal participation in medical assistance:

> (1)(A) Except as provided in paragraph (4), payment under the preceding provisions of this section shall not be made with respect to any amount expended as medical assistance in a calendar quarter, in any State, for any member of a family the annual income of which exceeds the applicable income limitation determined under this paragraph.
>
> (B)(i) Except as provided in clause (ii) of this subparagraph, the applicable income limitation with respect to any family is *the amount determined, in accordance with standards prescribed by the Secretary, to be equivalent to* 133⅓ percent of the highest amount which would ordinarily be paid to a family

> of the same size without any income or resources, in the form of money payments, under the plan of the State approved under part A of subchapter IV of this chapter [AFDC].

(emphasis added.)

This rule is further elaborated in the regulations implementing the statute:

> Medically needy income standards: General requirements.
>
> To determine eligibility of medically needy individuals, a Medicaid agency must use an income standard under this subpart that is—
>
> (a) Based on family size;
>
> (b) Uniform for all individuals in a covered group;
>
> (c) For FFP [Federal Financial Participation] purposes, not in excess of 133⅓ percent of the highest money payment that ordinarily would be made in the State AFDC program to an individual or a family of comparable size; and
>
> (d) Reasonable.

42 C.F.R. § 435.811 (1984).

> Medically needy.
>
> (a) FFP is available in expenditures for services provided to medically needy recipients whose annual income . . . does not exceed the following amounts . . .
>
> (1) For couples and families of two or more, 133⅓ percent of the highest money payment that would ordinarily be made under the State's AFDC plan to a family of the same size without income and resources.

42 C.F.R. § 435.1007.

The Administrator disapproved SPA 83-14 on the grounds that it violated the "plain and unequivocal" language of Section 1903(f) and the above regulations. However, the Administrator's narrow reading of the

statute fails to recognize sufficiently the substantive component of the MNIL determination. Section 1903(f) does not simply fix the applicable MNIL at 133⅓ percent of the highest amount ordinarily paid to a family of the same size without income or resources under a State's AFDC plan. The section provides that the applicable MNIL is "*the amount determined, in accordance with standards prescribed by the Secretary, to be equivalent to*" 133⅓ percent of the highest amount ordinarily paid to a family of the same size under AFDC. 42 U.S.C. § 1396b(f)(1)(B)(i) (emphasis added.) Had Congress intended that MNILs be determined purely as a mathematical procedure, it would not have included the above clause, which requires the Secretary to prescribe standards for determining an "equivalent" MNIL in relation to the comparative needs of medically needy and AFDC families of the same size. *See Batterton v. Francis*, 1977, 432 U.S. 416, 428: "Congress itself must have appreciated that the meaning of the statutory term was not self-evident, or it would not have given the Secretary the power to prescribe standards."

In response to a state's request "for a clarification of policy" regarding the establishment of MNILs under Section 1903(f), HHS promulgated Regional Office Manual (ROM) § 2572-D in June 1979. CCH Medicaid and Medicare Guide, ¶ 30,392 at 9512-13. This ROM provision set out HHS policy as to the specific problem addressed by the California plan amendment at issue here: the comparable income levels of medically needy adults and those of children in families receiving assistance under AFDC. Citing documentation that the maintenance needs of these groups are not equivalent, ROM § 2572-D states that "the States may set a separate medically needy income level for two adults which would be established between 133⅓ percent of the AFDC payment level for one person and 133⅓ percent of the AFDC payment level for a family of three

persons." HHS cites Montana as an example of a state which properly established an adult couple MNIL above the state AFDC level for a family of two. The ROM section concludes:

> In view of the greater maintenance needs of an adult as opposed to a child, . . . and in the interest of comparable treatment of persons with similar needs, the States should have the option of establishing separate medically needy income levels for a two-person family consisting of one adult and one child and for a two-person family composed of two adults.

In disapproving SPA 83-14, the Administrator rejected the State's reliance on ROM § 2572-D on the ground that "[t]he ROM section is patently contrary to the statute and was, therefore, invalid from its origination." This conclusion is based upon the improperly narrow construction of Section 1903(f) noted above. ROM § 2572-D is entirely consistent with the statutory requirement that the Secretary may promulgate standards for determining "equivalent" income limitations.

The Secretary also argues that the amendment is invalid under the ROM language allowing states to adopt an MNIL "between" 133⅓ percent of the AFDC payment level for one person and 133⅓ percent of the AFDC payment level for a family of three persons. Under the Secretary's view, SPA 83-14 would presumably have fulfilled the ROM criteria if California had set the adult couple MNIL at "one dollar less than" the maximum set out in the ROM section. However, ROM § 2752-D may be reasonably construed to include the maximum amount. The California plan amendment is therefore consistent with the ROM section.

Agencies must comply with their own regulations. *Ramon-Sepulveda v. INS*, 9 Cir., 1984, 743 F.2d 1307, 1310; *Dyniewicz v. United States*, 9 Cir., 1984, 742 F.2d 484, 485, even when the regulations are more generous

than required by law, *United States v. Newell*, 9 Cir., 1978, 578 F.2d 827, 834. However, "[n]ot all agency policy pronouncements which find their way to the public can be considered regulations enforceable in federal court." *Rank v. Nimmo*, 9 Cir., 1982, 677 F.2d 692, 698, quoting *Chasse v. Chasen*, 1 Cir., 1979, 595 F.2d 59, 62. The Secretary argues that the ROM is not a regulation, has no legal force and does not bind HCFA, citing the Hearing Officer's Recommended Decision. Appellants argue that whether the ROM section is labeled a "regulation," "directive" or "guideline," California had the right to rely on it in formulating SPA 83-14 and the Secretary must abide by its terms absent a proper repeal.

For ROM § 2572-D to have the "force and effect of law," it must satisfy both of the requirements set out by the Supreme Court in *Chrysler Corp. v. Brown*, 1979, 441 U.S. 281, 301-304. First, it must prescribe "substantive" or "legislative" rather than "interpretive" rules. *Id.* at 301-303. Second, its promulgation "must conform with any procedural requirements imposed by Congress." *Id.* at 303. *See also Rank, supra*, 677 F.2d at 698. We hold that ROM § 2572-D meets both parts of the *Chrysler* test and therefore bars the Secretary from disapproving the California plan amendment.

1. ***Legislative v. Interpretive Rules.***

Substantive or "legislative-type" rules are ones "affecting individual rights and obligations." *Chryser, supra*, 441 U.S. at 302, which "effect a change in existing law or policy," *Powderly v. Schweiker*, 9 Cir., 1983, 704 F.2d 1092, 1098, and which are "issued by an agency pursuant to statutory authority . . . and implement the statute, as, for example, the proxy rules issued by the Securities and Exchange Commision. . . " *Chrysler* at 302-3, citing *Batterton v. Francis, supra*, 432 U.S. at 425 n.9. *See also Alcaraz v. Block*, 9 Cir., 1984, 746 F.2d 593, 613; *Fmali*

Herb, Inc. v. Heckler, 9 Cir., 1983, 715 F.2d 1385, 1387. On the other hand, an interpretive rule is one issued without delegated legislative power. *Id.* at 1387. Such rules

> are essentially hortatory and instructional in that they go more 'to what the administrative officer thinks the statute or regulation means' *Gibson Wine Co. v. Snyder*, 194 F.2d 329, 331 (D.C. Cir. 1952), when applied in particular, narrowly defined situations. . . By merely clarifying the law's terms as applied situationally, interpretive or administrative-type rules are used more for discretionary fine-tuning than for general law making.

Alcaraz, supra, 746 F.2d at 613.

The Secretary describes ROM 2572-D as merely an "interpretive guideline." The label that an agency chooses to describe its action is "only indicative and not dispositive, of the agency's intent," which may be inferred from the forseeable effect that the rule will have. *Louisiana-Pacific Corp. v. Block*, 9 Cir., 1982, 694 F.2d 1205, 1210. Neither is the fact that the Secretary published this provision in the Regional Office Manual, and failed to do so in the Federal Register, dispositive on this issue. *See e.g., United States v. Coleman*, 9 Cir., 1973, 478 F.2d 1371.

The Secretary argues that the HCFA Regional Office Manual, like the SSA Claims Manual in *Schweiker v. Hansen*, 1981, 450 U.S. 785,

> is not a regulation. It has no legal force, and it does not bind the SSA. Rather it is a 13-volume handbook for internal use by thousands of SSA employees, including the hundreds of employees who receive untold numbers of oral inquiries like respondent's each year.

Id. at 789. The Supreme Court in *Schweiker* held that the "minor breach" of a provision in this manual by an SSA field representative (failure to follow a provision instructing representatives to advise applicants of the advantage

of filing written applications) did not estop the SSA from denying the applicant retroactive benefits according to a regulation limiting such benefits to one who "has filed [written] application." *Id.* at 786, 789. Referring to *Schweiker v. Hansen,* this court has held that other SSA claims manual provisions do not have "the force and effect of law." *Powderly,* 704 F.2d at 1096, 1098; *Whaley v. Schweiker,* 9 Cir., 1981, 663 F.2d 871, 873. Each of the above rules are interpretive, in that they instruct agency employees how the agency thinks a particular statue or regulation should be applied "in particular, narrowly defined situtations." *Alcaraz, supra,* 746 F.2d at 613. "These provisions only explain what the more general terms of the Act and regulations already provide." *Powderly, supra,* 704 F.2d at 1098.

It is clear that agency office manuals generally do not prescribe legislative rules with binding effect. However, the ROM section at issue in this case is an exception. Unlike the office manual provision in the above cases, ROM § 2572-D is not a field-level instructional guide to the application of the statute with respect to the inquiries and circumstances of particular individuals. It is directed not at office-level agency employees and specific recipients but at states and a major category of recipients under state plans. It establishes the right of states to increase their adult couple MNIL and thereby affects the rights of medically needy adults in all states with a Medicaid program. It establishes a new MNIL maximum in this category and thereby "effect[s] a change in existing law or policy," *Powderly, supra,* 704 F.2d at 1098. Most importantly, this case is distinguished from the cases cited by the Secretary by the statutory basis for the promulgation of ROM § 2572-D.

The question whether a given rule is legislative or interpretive turns on whether it is one "issued by an agency pursuant to statutory authority and . . . implement[s] the

statute," *Batterton, supra,* 432 U.S. at 425 n.9, or one "issued pursuant to an agency's interpretation of a governing statute without delegated power." *Fmali Herb, supra,* 715 F.2d at 1387. *See also Alcaraz, supra,* 746 F.2d at 613; *Louisiana-Pacific Corp., supra,* 694 F.2d at 1210.

In *Batterton,* the Supreme Court upheld a challenged regulation promulgated by the Secretary of HEW "pursuant to a delegation of rulemaking authority" in § 407(a) of the Social Security Act, 42 U.S.C. § 607(a). Like Section 1903(f) at issue in this case, Section 407(a) directed that a statutory term be "determined in accordance with standards prescribed by the Secretary."[1] The Supreme Court held that Congress "expressly *delegated* to the Secretary power to prescribe standards" for determining what constituted "unemployment" for purposes of program eligibility. *Id.* at 425 (emphasis in original).

> In a situation of this kind, Congress entrusts to the Secretary, rather than to the courts, the primary responsibility for interpreting the statutory term. In exercising that responsibility, the Secretary adopts regulations with legislative effect.

Id. See also Herweg v. Ray, 1982, 455 U.S. 265, 274-75; *Schweiker v. Gray Panthers,* 1981, 453 U.S. 34, 44. Noting that the Secretary's statutory authority to prescibe standards is not unlimited, the *Batterton* Court declared

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[1] 42 U.S.C. § 607. Dependent children of unemployed father; definition.

> "(a) The term 'dependent child' shall, notwithstanding section 606(a) of this title, include a needy child who meets the requirements of section 606(a)(2) of this title who has been deprived of parental support or care by reason of unemployment (*as detemined in accordance with standards prescribed by the Secretary*) of his father, and who is living with any of the relatives specified in section 606(a)(1) of this title in a place of residence maintained by one or more of such relatives as his (or their) own home." Cited in *Batterton,* 431 U.S. at 418 n.2 (emphasis added).

"we cannot say that the Secretary's regulation defeats the purpose of the [benefit] program" and upheld the regulation. *Batterton,* 432 U.S. at 429.

Unlike the statutes interpreted by the agency manuals in the cases cited by the Secretary, Section 1903(f) expressly authorized the Secretary to prescribe "standards." Congress must have intended that standards thus prescribed by HHS would have the force and effect of law. In promulgating the ROM provision at issue, the Secretary followed the mandate of Section 1903(f). This provision on its face sets out standards for determining "equivalent" adult couple MNILs in relation to payment levels under state AFDC plans. ROM § 2572-D is therefore a rule "issued by an agency pursuant to statutory authority and . . . implements the statute," *Batterton, supra,* 432 U.S. at 425 n.9. Because we cannot say that it defeats the purpose of the Medicaid program, *id.* at 428-29, we conclude that ROM § 2572-D is a proper legislative rule.

2. ***Procedural Requirements Imposed by Congress.***

Once an agency rule or regulation has been determined to be substantive, it nevertheless will not have "the force and effect of law" unless its promulgation conforms "with any procedural requirements imposed by Congress." *Chrysler Corp., supra,* 441 U.S. at 303.

Notice and comment procedures set out in the Administrative Procedure Act (APA) generally apply to agency rulemaking with the exception of "interpretive rules, general statements of policy, or rules of agency organization, procedure, or practice." 5 U.S.C. § 553(b)(A). ROM § 2572-D was not promulgated according to APA procedures. However, the APA requirements do not apply "to the extent there is involved . . . a matter relating to . . . public property, loans, grants, *benefits,* or contracts." 5 U.S.C. § 553(a)(2) (emphasis added). The ROM section at issue expressly concerns Medicaid, a

benefit program, and falls under the statutory exemption, *Cf. Good Samaritan Hospital, Corvalis v. Mathews,* 9 Cir., 1979, 609 F.2d 949, 953-54; *Baylor University Medical Center v. Heckler,* 5 Cir., 1985, 758 F.2d 1052, 1058; *Bedford County General Hospital v. Heckler,* 6 Cir., 1985, 757 F.2d 87, 90; *Humana of South Carolina v. Califano,* D.C., Cir., 1978, 590 F.2d 1070. 1083-84 & n.102. *See also Alcaraz v. Block, supra,* 746 F.2d at 611.

The Secretary voluntarily waived the APA "benefits" exception in 1971. 36 Fed. Reg. 2532 (1971); *Good Samaritan Hospital, supra,* 609 F.2d at 954. The Department thereby imposed upon itself procedural requirements "not required by law." 36 Fed. Reg. 2532. The Secretary's waiver has a binding effect independent of the APA, *see Buschman v. Schweiker,* 9 Cir., 1982, 676 F.2d 352, 356 n.4; *cf. Rodway v. Department of Agriculture,* D.C. Cir., 1975, 514 F.2d 809, 814, and would operate to invalidate a challenged substantive rule limiting benefits promulgated in violation of the requirements set out in the APA. However, the 1971 waiver does not overrule or otherwise abrogate Section 553(a)(2), a section which has not been repealed and remains in effect. "[R]ulemaking requirements for agencies managing benefit programs are still voluntarily imposed—i.e., agency-created statutory exceptions. Thus, it is only the Department's own statement of policy that applies the notice and comment provisions to rulemaking in these programs." *Alcaraz, supra,* 746 F.2d at 611. In promulgating ROM § 2572-D, the Secretary failed to abide by her predecessor's promise to adopt APA rulemaking procedures. Nevertheless, these were not "procedural requirements imposed by Congress." *Chrysler Corp., supra,* 441 U.S. at 303.

The APA procedural requirements exist to protect the public's interests, not to shelter the Secretary. As the D.C. Circuit stated, "The essential purpose of according § 553 notice and comment opportunities is to reintroduce public

participation and fairness to affected parties after governmental authority has been delegated to unrepresentative agencies." *Batterton v. Marshall,* D.C. Cir., 1980, 648 F.2d 694, 703. This case does not involve a defectively promulgated regulation challenged by members of the public who claim that they were harmed by losing their right to participate in the administrative rulemaking process. On the contrary, the State and Intervenors emphasize that they had full awareness of the promulgation and existence of ROM § 2572-D. The Secretary does not dispute this. She argues that the ROM section is an "interpretive guideline" that need not be published under the APA or Freedom of Information Act (FOIA), but she also argues that, because California had actual and timely notice of the ROM terms, lack of publication should not be fatal, citing *United States v. Mowat,* 9 Cir., 1978, 582 F.2d 1194, 1201. *See also United States v. Hall,* 9 Cir., 1984, 742 F.2d 1153, 1155; *Nason v. Kennebec County CETA,* 1 Cir., 1981, 646 F.2d 10, 19.

The FOIA requires agencies to publish in the Federal Register not only "substantive rules of general applicability adopted as authorized by Law" but also "statements of general policy or interpretation of general applicability formulated and adopted by the agency," 5 U.S.C. § 552(a)(1)(D) and "each amendment, revision, or repeal of the foregoing," § 552(a)(1)(E). There is no "benefits" exemption from the FOIA publication requirement. However, this requirement "attaches only to matters which if not published would adversely affect a member of the public." *Zaharakis v. Heckler,* 9 Cir. 1984, 744 F.2d 711, 714, citing *Hogg v. United States,* 6 Cir., 1970, 428 F.2d 274, 280. The Secretary's failure to publish the ROM provision in 1977 in accordance with the FOIA therefore does not affect the validity of the provision. *See Rodriguez v. Swank,* 318 F.Supp. 289, 295, *aff'd* 403 U.S. 901.

We conclude that ROM § 2572-D meets both prongs of the *Chrysler* test. It is a legislative rule issued pursuant to statutory authority; its promulgation violated no procedural requirements imposed by Congress. The ROM provision became effective June 1979. When the California legislature enacted SPA 83-14 it had not been properly repealed by HHS nor even removed from publication. ROM § 2572-D therefore had "the force and effect of law," *Chrysler, supra,* 441 U.S. at 301-305, and barred the Secretary from disapproving the California plan amendment which conformed to its terms.

B. ***The Deficit Reduction Act (DEFRA).***

The Act, Pub. L. 98-369, Section 2373(c) provides an additional, independent reason for reversal. This section established a moratorium during which the HHS Secretary

> shall not take any compliance, disallowance, penalty, or other regulatory action against a State . . . by reason of such state's [Medicaid] plan . . . being determined to be in violation of [Social Security Act] section 1902(a)(10)(C)(i)(III).

DEFRA Section 2373(c)(1). This moratorium began when DEFRA was enacted in July, 1984, before the Secretary's final disapproval of SPA 83-14 in January, 1985. It continues until 18 months after the Secretary reports to Congress as required by DEFRA Section 2373(c)(3). Section 2373(c)(2).

Section 1902(a)(10)(C)(i)(III), adopted as a provision of the Tax Equity and Fiscal Responsibility Act (TEFRA) requires that a state medicaid plan which provides benefits to medically needy recipients include a description of

> the single standard to be employed in determining income and resource elegibility for all such groups, in the methodology to be employed in determining such eligibility, which shall be the same methodology

> which would be employed under the . . . appropriate State [cash assistance] plan. . . .

42 U.S.C. § 1396a(a)(10)(C)(i)(III).

Appellants argue that the DEFRA moratorium applies directly to prevent the Secretary from rejecting the California Medi-Cal amendment. They point out that prior to the Administrator's disapproval of SPA 83-14, HCFA stated in agency memoranda and in a letter to the State that such a plan would violate the "single standard" requirement of TEFRA. The Secretary correctly points out that neither the initial nor final decisions disapproving SPA 83-14 expressly claim that the plan amendment violated TEFRA. Her decision relies entirely on the argument that the California plan violated Section 1903(f). However, the California plan amendment raises exactly the kind of problem which Congress addressed by establishing a moratorium on HHS implementation of the TEFRA "single standard" provision.

The California legislature enacted the Medicaid plan amendment in response to findings that a single standard did not accurately reflect the comparative need of medically needy adults and children in families receiving assistance under AFDC. Although the Administrator's final decision did not expressly cite Section 1902(a)(10)(C)(i)(III), that decision nevertheless recognized that the California plan amendment raises a TEFRA "single standard" issue.

> *Regardless of the possibly greater maintenance needs of a two-adult family as opposed to an AFDC family of two (one child, one adult),* the statute provides for a single MNIL for a family of two.

Decision of the Administrator at 4 (emphasis added).

Congress intended the DEFRA moratorium to apply in precisely this situation. The DEFRA Conference Committee Report explains that Section 2373 was enacted to cor-

rect HHS's "overly restrictive" interpretation of the TEFRA provision. 130 Cong. Rec. H6741 (daily ed. June 22, 1984). One of the examples cited by the conferees corresponds directly to the facts of this case:

> [T]he Department has taken the position, that the 'single standard' requirement of the TEFRA amendment prohibits States from establishing less restrictive medically needy income levels for single adults and couples because this would result in differences in medically needy income levels among groups of the same size depending on the relative members of adults and children.

Id. The Conference Report explains that Congress enacted Section 2373 to prevent the Secretary from taking, during the moratorium period, "any compliance, disallowance, penalty or other regulatory action against a State because a State, in determining eligibility for noncash Medicaid recipients, is using *an income or resource standard or methodology that is less restrictive than the applicable cash assistance standard or methodology.*" *Id.* (emphasis added.) There is no statutory basis for the Secretary's argument that the DEFRA moratorium applies only to already "existing and approved plans." In disapproving SPA 83-14, the Secretary improperly penalized California, in violation of DEFRA Section 2373(c), for adopting a different, less restrictive methodology than that used under the California AFDC plan for a family of two.

IV. *Conclusion.*

The California Medicaid plan amendment at issue conforms to the MNIL standards prescribed by the Secretary pursuant to Section 1903(f) of the Social Security Act, set out in ROM § 2572-D. The Secretary's determination that SPA 83-14 violates Section 1903(f) is therefore arbitrary and capricious. Moreover, the Secretary's disapproval of

SPA 83-14 violates DEFRA Section 2373(c) and is therefore not in accordance with law.

Because we reverse the Secretary's final determination on statutory grounds, we need not reach the due process claim raised by Intervenors.

The Secretary's decision disapproving SPA 83-14 is REVERSED.

APPENDIX B

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

No. 85-7123

STANLEY CUBANSKI, DIRECTOR,
DEPARTMENT OF HEALTH SERVICES
STATE OF CALIFORNIA, PETITIONER,

AND

DONALD A. BARRIER, ALAN BIERMAN, LOLA BIERMAN,
JAMES JONES, RONALD KWIEK, PETITIONERS-INTERVENORS,

v.

MARGARET HECKLER, SECRETARY,
DEPARTMENT OF HEALTH AND HUMAN SERVICES,
UNITED STATES OF AMERICA, RESPONDENT.

Filed March 6, 1986

ORDER

Before: DUNIWAY, CHOY, and FARRIS,
Circuit Judges

It is hereby ordered that the next to the last line on page 5 of the slip opinion in this case is amended to read as follows:

> of two medically needy adults to 133-⅓% of the highest amount that . . .

APPENDIX C

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

No. 85-7123 (CA SP 83-14)

STANLEY CUBANSKI, DIRECTOR,
DEPARTMENT OF HEALTH SERVICES
STATE OF CALIFORNIA, PETITIONER,

AND

DONALD A. BARRIER, ALAN & LOLA BIERMAN, ET AL.,
PETITIONERS-INTERVENORS,

v.

MARGARET HECKLER, SECRETARY,
DEPARTMENT OF HEALTH AND HUMAN SERVICES,
UNITED STATES OF AMERICA, RESPONDENT.

Mandate Issued July 23, 1986

File and Entered: Feb. 7, 1986

PETITION FOR REVIEW OF A DECISION OF THE DEPARTMENT OF HEALTH AND HUMAN RESOURCES

JUDGMENT

This Cause came on to be heard on the Transcript of the Record from the Department of Health and Human Services, and was duly submitted.

On Consideration Whereof, it is now here ordered and adjudged by this Court, that the Order of the said Department of Health and Human Services in this Cause be, and hereby is REVERSED.

APPENDIX D

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

No. 85-7123

STANLEY CUBANSKI, DIRECTOR,
DEPARTMENT OF HEALTH SERVICES
STATE OF CALIFORNIA, PETITIONER,

AND

DONALD A. BARRIER, ALAN BIERMAN, LOLA BIERMAN,
JAMES JONES, RONALD KWIEK, PETITIONERS-INTERVENORS,

v.

OTIS R. BOWEN, M.D. (FORMERLY MARGARET HECKLER),
SECRETARY, DEPARTMENT OF HEALTH AND HUMAN
SERVICES, UNITED STATES OF AMERICA, RESPONDENT.

Filed July 14, 1986

ORDER

Before: DUNIWAY, CHOY, and FARRIS,
Circuit Judges

A member of this court having called for a vote on taking this case in banc, and a majority of the members having voted against taking the case in banc, the suggestion of a rehearing in banc is rejected, and the petition for a rehearing is denied.

APPENDIX E

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

No. 85-7123

STANLEY CUBANSKI, DIRECTOR,
DEPARTMENT OF HEALTH SERVICES
STATE OF CALIFORNIA, PETITIONER,

AND

DONALD A. BARRIER, ALAN BIERMAN, LOLA BIERMAN,
JAMES JONES, RONALD KWIEK, PETITIONERS-INTERVENORS,

v.

MARGARET HECKLER, SECRETARY,
DEPARTMENT OF HEALTH AND HUMAN SERVICES,
UNITED STATES OF AMERICA, RESPONDENT.

Filed July 18, 1986

DISSENT

KOZINSKI, *Circuit Judge,* with whom Circuit Judges SNEED, HALL and NOONAN join, Dissenting from the rejection of the suggestion for rehearing en banc.

The panel's opinion in this case is a study in judicial legislation. Disregarding principles of administrative law long established by the Supreme Court and this court, the opinion gives birth to a sweeping new doctrine: that a federal court may endow an agency's internal operating manual with the force of law. In so doing, the panel fails to acknowledge that the manual in question was prepared by government employees lacking authority to issue regulations; was expressly limited to use within the agency; and contravened properly issued regulations, that the

panel over-rules *sub silentio*. Equally unprecedented is the panel's alternative ruling, reversing the Secretary for the curious reason that his decision cannot be sustained under an inapplicable statute on which he did not rely. It is difficult to reconcile the opinion's tortuous path with the Supreme Court's admonition that administrative decisions not be set aside "simply because the court is unhappy with the result reached." *Vermont Yankee Nuclear Power Corp.* v. *NRDC*, 435 U.S. 519, 558 (1978).

Aside from the severe financial impact this case will have by its own force—the government estimates $50 million annually, Pet. Reh. at 1 n.1—its precedential effect as the law of the nation's largest circuit is difficult to overestimate. The opinion seriously blurs lines dividing regulations from other agency issuances, and separating those employees who may lawfully bind the agency from those who may not. By making every federal agency's operating manuals and internal guidelines fair game to a claim that they carry the force of law, the opinion will wreak havoc with administrative decision-making, and shift significant power from the Executive Branch to the courts.

These arguments, and others discussed below, are advanced crisply and persuasively in Respondent's Petition for Rehearing with Suggestion for Rehearing En Banc. They remain unanswered and, to my mind, unanswerable. Yet answers they deserve. If the panel is unwilling or unable to address these contentions, the full court should. Because I believe the court did not live up to its grave responsibility for maintaining the fabric of the law intact, I respectfully dissent.

FACTS

This case concerns the extent of federal participation in Medi-Cal, California's version of Medicaid. Title XIX of

the Social Security Act, 42 U.S.C. § 1396 *et seq.* (1982 & Supp. 1985), sets standards for such participation. Specifically, a state must provide medical assistance to recipients of welfare benefits. 42 U.S.C. § 1396a(a)(10)(A) (1982). In addition, a state may provide Medicaid coverage to various groups (e.g. the aged, blind or disabled) who are ineligible for welfare because their income is somewhat too high, but who are nevertheless poor. These people are deemed "medically needy." *Id.* §§ 1396a(a)(10)(C), 1396d. Each state must define who is medically needy in accordance with federal standards, *id.* § 1396a(a)(10)(C)(i); the income standard for such recipients is known as the "medically needy income level" or MNIL.

At issue in this case is California's attempt to loosen the standards for Medi-Cal eligibility by increasing the MNIL for a family of *two* medically needy adults to 133-⅓% of the highest amount that would be paid to a family of *three* under AFDC. The Health Care Financing Administration (HCFA) disapproved the proposed revision because it violated 42 U.S.C. § 1396b(f) (1982). The Secretary affirmed.

A panel of this court reversed, basing its decision on alternative rulings. First, the panel concluded that the Secretary's interpretation of section 1396b(f) was inconsistent with a section of HCFA's Regional Office Manual (ROM). The panel held that this provision was a legislative regulation and interpreted it as allowing California's increase in the MNIL. The panel also held that the Secretary's action was barred by section 2373(c)(1) of the Deficit Reduction Act (DEFRA), Pub. L. 98-369, which imposes a moratorium on certain regulatory actions against state Medicaid plans.

DISCUSSION

1. *The Statute, the Regulation and the ROM*

The statute provides that a family's MNIL is "the amount determined, in accordance with standards prescribed by the

Secretary, to be equivalent to 133-⅓ percent of the highest amount which would ordinarily be paid [under AFDC] to a family of the *same* size without any income or resources[.]" 42 U.S.C. § 1396b(f)(1)(B)(i) (1982) (emphasis added). The panel rejected the Secretary's argument that this section limited the MNIL to 133-⅓% of the maximum AFDC payment families of the *same* size could receive, pointing to the phrase "in accordance with standards prescribed by the Secretary." The panel reasoned that this language allows the Secretary to devise a formula permitting states to set the MNIL at more than 133-⅓% of the maximum amount payable under AFDC to families of the same size. The panel then held that HCFA's Regional Office Manual § 2572-D is that formula. It interpreted this ROM section as allowing the State to set the MNIL in terms of the income of an AFDC family of a different size. The panel rejected the Secretary's attempt to repudiate this ROM section. It held that the provision is a legislative regulation, having the force and effect of law, binding on the Secretary. 781 F.2d at 1424-29. The panel errs in almost every respect.

A.

Most fundamentally, the Regional Office Manual is not a body of regulations. As its name suggests, the ROM is an *office manual,* an internal directive from the agency's headquarters to its field offices. The manual's Foreword emphasizes this point:

> The Health Insurance Regional Office Manual (ROM) is the principal channel for transmitting program instructions of on-going reference value to regional offices. . . .

> The ROM is not intended to stand alone but rather to serve as the regional supplement to other health insurance manuals; e.g., provider manuals, intermediary manuals. Therefore, substance in other issuances will not generally be repeated. Appropriate cross-references will be used instead.
>
> . . . .
>
> This manual is for the use of regional office employees only and should not be cited when addressing contractors, State agencies, providers, etc.

HCFA Regional Office Manual Part 6 (Medicaid) iii.

As the panel recognizes, numerous cases in the Supreme Court and this court stand for the proposition that the contents of such manuals are not regulations, have no legal force and do not bind the agency. *See Schweiker* v. *Hansen,* 450 U.S. 785, 789 (1981) (SSA Claims Manual); *Powderly* v. *Schweiker,* 704 F.2d 1092, 1096, 1098 (9th Cir. 1983) (same); *Whaley* v. *Schweiker,* 663 F.2d 871, 873 (9th Cir. 1981) (same); *see also Evelyn* v. *Schweiker,* 685 F.2d 351, 352 n.5 (9th Cir. 1982) (Program Operations Manual System). The panel cites no case to the contrary and careful research reveals none.

The panel's attempt to distinguish these cases is far off the mark. For example, it states:

> Unlike the office manual provision in the above cases, ROM § 2572-D is not a field-level instructional guide to the application of the statute with respect to the inquiries and circumstances of particular individuals. It is directed not at office-level agency employees and specific recipients but at states and a major category of recipients under state plans.

781 F.2d at 1426-27. The panel gives no citation for this counterintuitive assertion. Nor do I believe it could, since

it flies in the face of the ROM's own description of itself: "This manual is for the use of regional office employees only and *should not be cited when addressing* contractors, *State agencies,* providers, etc." ROM Pt. 6, at iii (emphasis added).

One searches the opinion in vain for an explanation of how the panel's ruling can be squared with this disclaimer, or even an acknowledgment that the disclaimer exists. Nor does the panel explain why something called an office manual would contain procedures "directed not at office-level agency employees . . . but at states and a major category of recipients under state plans." 781 F.2d at 1426-27.

The panel goes on to assert that the ROM "establishes the right of states to increase their adult couple MNIL" and "thereby 'effect[s] a change in existing law or policy [.]' " *Id.* at 1427 (quoting *Powderly,* 704 F.2d at 1098). But this merely assumes the conclusion. A provision can effect a change in existing law or policy only if it has the force of law; if it does not, it cannot.

The panel further claims that the ROM has the force of law because it has a "statutory basis:"

> Unlike the statutes interpreted by the agency manuals in the cases cited by the Secretary, Section 1903(f) expressly authorized the Secretary to prescribe "standards." Congress must have intended that standards thus prescribed by HHS would have the force and effect of law. In promulgating the ROM provision at issue, the Secretary followed the mandate of Section 1903(f).

Id. at 1427. But words on paper do not become legislative regulations merely because the Secretary could have promulgated them as such; he must actually have done so. The Secretary, however, denies doing any such thing, and all available evidence supports his claim.

Congress granted the authority to promulgate rules and regulations to the Secretary alone, *see* 42 U.S.C. § 1302 (1982), authority he has jealousy retained.[1] There is absolutely no indication that the Secretary had anything to do with writing or approving HCFA's Regional Office Manual, or any part of it. The Regional Office Manual is a publication of HCFA, an operating division of HHS. Like thousands of other internal guidelines issued every year by scores of federal agencies, ROM updates are issued anonymously; the Foreword alone is signed and that by the Director of the Bureau of Health Insurance, an official far subordinate to the Secretary. ROM Pt. 6, at iv. Guidelines issued by someone without authority to promulgate regulations are simply not regulations. *See General Electric Co.* v. *Gilbert,* 429 U.S. 125, 141 (1976). This alone conclusively refutes the panel's assertion that ROM § 2572-D was promulgated pursuant to the authority of Section 1396b(f) and is binding on the Secretary. 781 F.2d at 1427.

But there is much more. The Secretary in fact *has* promulgated regulations on this very subject, regulations that plainly conflict with ROM § 2572-D and the panel's decision. *See* 42 C.F.R. §§ 435.811, .1007 (1985). These regulations provide that federal participation

> is available in expenditures for services provided to medically needy recipients whose annual income . . . does not exceed the following amounts . . . : (a) For couples and families of two or more, 133-⅓ percent of the highest money payment that would ordinarily

[1] While the Secretary had made various delegations to the Administrator of HCFA by the time ROM section 2572-D was issued, he specifically retained the authority to issue regulations, 44 Fed. Reg. 31045 (May 30, 1979) (Statement of Organization, Functions, and Delegations of Authority).

> be made under the State's AFDC plan *to a family of the same size* without income and resources.

Id. § 435.1007 (emphasis added). The ambiguity the panel detected in the statutory language is neatly excised by these regulations. The regulations are a valid exercise of the Secretary's authority and therefore have the force of law. To conclude, as the panel in effect does, that the Regional Office Manual takes precedence, violates the axiom that federal regulations may not be contravened by subordinate employees who lack authority to bind the agency. *Federal Crop Insurance Corp.* v. *Merrill,* 332 U.S. 380, 384-85 (1947). In any collision between regulations and instructions in an office manual, the regulations must prevail. Moreover, the very existence of conflicting regulations issued by the Secretary contradicts the panel's assertion that the anonymous ROM update represented the Secretary's exercise of authority pursuant to 42 U.S.C. § 1396b(f).

The panel's opinion quotes the regulations, 781 F.2d at 1424, but ignores them; it does not attempt to reconcile the obvious conflict between the regulations and ROM § 2572-D, the linchpin of its decision; it does not even acknowledge the tension between the two. The panel effectively reads the regulations out of existence without any explanation or admission of the fact.

B.

Even if ROM § 2572-D had been promulgated as a regulation, it would be invalid because it violates the plain language of the statute. While section 1396b(f)(1) gives the Secretary discretion to determine how the MNIL amount is to be calculated, the calculation must in fact aim at approximating the AFDC income of a family of the *same* size. It renders language meaningless to say, as does the panel, that the Secretary may formulate the MNIL in

terms of the amount to be paid to a family of a *different* size.[2] Read in this fashion, the statute provides no limits whatsoever on the Secretary's discretion and might as well say "the Secretary may set the MNIL any way he pleases."

C.

Troubling as I find the panel's result, it is its method, with its explosive potential, that causes me the greatest alarm. I had thought it firmly established that a court may not roam through the vast libraries of federal agency publications, borrowing from those it likes and ignoring the rest. Agency publications come in many forms and levels of dignity—from press releases to regulations promulgated after notice and comment; and they are issued by a variety of agency officials—from GS-15 field office chiefs to Cabinet Secretaries. Regulations properly issued by a Cabinet Secretary pursuant to authority delegated to him by Congress, I had thought, took precedence over all other agency issuances and, unless held to be invalid, conclusively resolve the legal issues they address. I had also thought that an agency could safely issue internal guidance to its employees without binding itself to outsiders by: (a) confining issuances to internal procedure manuals; (b) failing to attribute them to anyone with authority to promulgate regulations; and (c) expressly disclaiming the intent to promulgate regulations.

The panel's opinion tears asunder these tenets of administrative law, replacing them with nothing more substantial than its assurance that ROM § 2572-D is "an exception." 781 F.2d at 1426. But the panel gives no accurate account of what makes it an exception; everything it says about ROM § 2572-D could fairly be said about a great many other office manuals issued by federal agen-

[2] In certain limited circumstances section 1396b(f)(1)(B)(ii) allows the Secretary to set the MNIL amount higher than 133-⅓% of the

cies. Lawyers in the nine western states will now have a field day prospecting for other such nuggets within the thousands of pages of internal instructions issued by agencies regulating vast areas of the law: tax, personnel, transportation, agriculture, the environment, to name a few.

Having created uncertainty where stability is vital, the panel's methodology will breed litigation which will then beget further uncertainty. While this may be a bonanza for lawyers, and give immense power to courts to meddle in the affairs of the Executive Branch, it will cause no end of headaches for agency officials who will now have to guess which of their informal, unsigned, internal guidelines will be found "exceptional" enough to outrank regulations. That door, it seems to me, was slammed shut by the Supreme Court in cases such as *Schweiker* v. *Hansen* and *Federal Crop Insurance* v. *Merrill*. It should remain that way.

2. *The Deficit Reduction Act (DEFRA)*

A.

Perhaps not entirely comfortable with its principal ruling, the panel offers an alternative: that the Secretary's action violated DEFRA's moratorium on certain regulatory actions. During the moratorium period, the Secretary may not disapprove state Medicaid plans if such denial is premised on the fact that they violate the so-called "same methodology" or "single standard" rule.[3] As the Supreme

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amount paid to a family of the same size under a state's AFDC plan. But this exception applies only if a state's AFDC plan provides that some large families with different numbers of children get equal amounts. The panel renders this congressionally-approved exception a nullity, since under its holding the Secretary would have authority to reach the same result under (B)(i).

[3] The terms appear to be synonymous. Section 1396a(a)(10(C)(i) requires state plans to describe the criteria for membership in the vari-

Court recently explained in *Atkins* v. *Rivera*, 54 U.S.L.W. 4731, 4734 (June 24, 1986), the "same methodology" rule deals with the question of what resources are counted toward income in determining Medicaid eligibility. The statute provides that a state must use the "same methodology" in establishing an applicant's eligibility for Medicaid as it would if he were applying for other welfare programs, typically AFDC and SSI. That is, if a resource (such as interest) is counted toward establishing eligibility for AFDC or SSI, it must also be counted for purposes of Medicaid. 54 U.S.L.W. at 4733.

As the Supreme Court further explained, in 1981 the Secretary promulgated regulations that weakened the "same methodology" rule by permitting the States "to use eligibility standards that were unrelated to the standards used in AFDC or SSI, as long as the standards were 'reasonable.' " 54 U.S.L.W. at 4734 (footnote omitted). Congress disapproved this approach and in 1982 passed 42 U.S.C. § 1396a(10)(C)(i)(III) as part of the Tax Equity and Fiscal Responsibility Act (TEFRA) for the sole purpose of invalidating these regulations. 54 U.S.L.W. at 4734. Two years later, Congress had second thoughts and passed the DEFRA moratorium in order to block the operation of TEFRA for a period of 18 to 30 months. *Id.* at 4734 n.10. It is this latest chapter in the "same

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ous groups of medically needy individuals (e.g. the old, the blind, the disabled) and to describe

> the single standard to be employed in determining income and resource eligibility for all such groups, and the methodology to be employed in determining such eligibility, which shall be the same methodology which would be employed under [e.g. AFDC or SSI].

The panel refers to this section as the "single standard" requirement, *see* 781 F.2d at 1429, while the Supreme Court refers to it as the "same methodology" requirement, *see* 54 U.S.L.W. at 4732.

methodology" controversy on which the panel relies as its alternative basis for striking down the Secretary's ruling.

As *Atkins* makes clear, however, the DEFRA moratorium, and the "same methodology" question it addresses, has nothing at all to do with this case. The "same methodology" requirement deals with what resources are counted in defining income. The question here is how much income (however defined) a family may have and still be considered medically needy.[4] The two provisions have about as much in common as apples and pineapples: They sound vaguely similar but they grow on entirely different statutory trees.

B.

In addition to fundamentally misreading the statute, the panel errs by applying DEFRA's moratorium to something that is not yet a state plan, only a proposed plan. DEFRA, by its terms, prohibits the Secretary from taking any regulatory action against a "State's [Medicaid] plan." Until approved by the Secretary, California's proposed amendment does not become part of its plan and therefore cannot benefit from the moratorium. This interpretation comports not only with the language of the statute but with common sense as well. Under the panel's interpretation, states may raise the MNIL as high as they want during the moratorium and force the federal government to contribute. So construed, DEFRA removes significant federal fiscal control over Medicaid participation, risking a hemorrhage of federal funding for this program.

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[4] Whether alimony is considered for the purpose of establishing Medicaid eligibility is a "same methodology" question; whether the income exceeds the maxium a family of two or a family of three could receive under AFDC is not.

C.

Finally, I have considerable difficulty with the panel's contorting of the Secretary's decision in order to strike it down. The Secretary quite properly relied on section 1396b(f) in disapproving California's proposed plan, not on section 1396a(C)(i)(III), the subject of the DEFRA moratorium. In order to find fault with the Secretary's action, the panel tells the Secretary that he acted with motives he denies having and pursuant to statutory powers he denies exercising. Such psychoanalysis of administrative decision-making far exceeds the bounds of judicial review. If the Secretary properly bases his decision on a particular statutory provision, as he did here, it is irrelevant that he could (or could not) have based his decision on something else.

CONCLUSION

In law, as in life, two wrongs add up to two wrongs, nothing more. Neither of the panel's chosen pathways lead to the result it reaches; they certainly cannot not do so in tandem. In reaching that result anyway, the opinion muddies the waters in two important areas of the law. I would take the case en banc, vacate the panel's opinion, affirm the Secretary's decision and set the law of the circuit back on course.

APPENDIX F

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration
6325 Security Boulevard
Baltimore, MD 21207

Certified Mail

Ralph M. Johnson, Esq.
Deputy Attorney General
350 McAllister Street
Room 6000
San Francisco, California 94102

Dear Mr. Johnson:

Re: *California State Plan Amendment No. 83-14,*
Docket No. 84-6

I have enclosed a copy of the Administrator's final decision regarding *California State Plan Amendment No. 83-14.*

By copy of this letter, I am transmitting to the other parties a copy of the final decision. This decision constitutes a "final determination" within the meaning of section 1116(a)(3) of the Social Security Act and 45 CFR 201.7, and "final agency action" within the meaning of 5 U.S.C. 704. If the State is dissatisfied with this determination, it may, within sixty (60) days after receipt of this decision, file with the United States Court of Appeals for the Ninth Circuit a petition for review.

Sincerely yours,

/s/ IRWIN COHEN
Irwin Cohen
Attorney-Advisor

Enclosure

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DEPARTMENT OF HEALTH AND
HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

Docket No. 84-6

IN THE MATTER OF:

CALIFORNIA
STATE PLAN AMENDMENT 83-14

DECISION OF THE ADMINISTRATOR

This case is before the Administrator, Health Care Financing Administration (HCFA), for final agency action under § 1116 of the Social Security Act, as amended [42 USC 1316]. The State of California, the Regional Attorney for HCFA, and the Legal Aid Society of Alameda County submitted exceptions to and comments on the Hearing Examiner's Recommended Decision. The time for submitting such exceptions has now expired. Accordingly this matter is ready for the Administrator's final decision pursuant to 45 CFR 213.32.

The entire record which was furnished by the Hearing Examiner has been carefully reviewed, including all the parties' briefs, exhibits, declarations, depositions, the transcript of the oral hearing, and the parties' post-hearing submissions. The Hearing Examiner's Recommended Decision has been considered by the Administrator. All correspondence and exceptions sent or received after entry of the Recommended Decision have been made a part of the record and all exceptions and related arguments were examined.

This matter concerns a request (February 16, 1984) by the State of California to the Associate Regional Admin-

istrator (Region IX) of HCFA. The request sought reconsideration of the Administrator's disapproval of State Plan Amendment 83-14 which proposed to increase the medically needy income level (MNIL) and to provide a separate MNIL for families of two adults. At issue in this matter is the Administrator's initial finding in which the Hearing Examiner concurred. These decisions held that the State's plan amendment could not be approved because the provision for an adult couple MNIL violated requirements placed upon state plans under Title XIX.

The Deputy Attorney General for the State of California submitted exceptions to the Hearing Examiner's Recommended Decision. These exceptions concerned a finding that the State had not relied on Regional Office Manual (ROM) § 2572, and they pointed out that the ROM had never been invalidated by regulations even though that was predicted by a HCFA policy official. The State contends that evidence in the record shows that HCFA employees knew before the California legislature acted that California planned to act in accordance with the ROM. Other evidence is cited by the State which is interpreted to reflect the reliance placed upon the ROM by the State's legislature. Because of this reliance, the State argues that the Recommended Decision is unsupported by the record.

The Department of Health and Human Services' Assistant Regional Attorney replied to the State's exceptions and commented that the evidence cited by the State is not credible to prove that the State did rely on the ROM. Citing other evidence and declarations, the DHHS attorney states that the one leading sponsor of the State's legislation, whose remarks were introduced into the record, did not even refer to the ROM as a reason behind the change. The Regional Attorney reasoned that evidence of awareness is not the same as proof of actual reliance.

These comments also make two additional observations, first—that even if the State had relied upon the ROM, HCFA never lead the State to do so; and second—that the Hearing examiner's finding concerning the State's reliance is not central to the controversy here, and such reliance would not invalidate the HCFA's determination.

The Legal Aid Society of Alameda County on behalf of Intervenors, affected adult couples in California, also submitted exceptions. The Society contends that the State relied on the ROM and cited the Commerce Clearing House, *Medicare and Medicaid Guide* and 42 CFR 201.3(c) to show that such reliance was appropriate. The cited regulation states that policy statements and precedent approved by the Administrator serve as the basis for action on state plans. The society concludes from this that the ROM was such a policy statement and was part of a body of substantive pronouncements upon which the State may rely.

The Society also considered the Hearing Examiner's finding that the 1984 Deficit Reduction Act supported HCFA's refusal to implement the ROM and that the moratorium enacted at DRA § 2373(c) did not apply. The exceptions charged that there is no evidence that when Congress rejected the House version (which adopted the ROM "interpretation of § 1903(f)" of the Societ Security Act), it supported HCFA's position. Instead, according to the Society, Congress made it clear that during the moratorium States could establish less restrictive adult couple MNILs without sanction. The Intervenors' attorney further argued that the "Recommended Decision" avoided the moratorium imposed on the agency under the DRA, and that to adopt the Hearing Examiner's opinion would flout the will of Congress.

Throughout these proceedings the Society has urged that the State be given an opportunity to submit a con-

forming plan amendment. In its exceptions, the Intervenors' counsel again urges that this opportunity be afforded prior to the application of sanctions. In excepting to the Hearing Examiner's opinion the Society observes that these proceedings are governed by 45 CFR 201.6 rather than § 201.4 as the "Recommended Decision" concludes. Accordingly, the proceedings would directly involve sanctions. Under either provision, the Society comments, sanctions may be forthcoming which should be stayed until the State has an opportunity to correct its plan.

The Administrator has carefully examined the exceptions by the State, by the Legal Aid Society on behalf of the Intervenors, and the comments in reply to the State submitted by the Assistant Regional Attorney. As a result of this analysis, the Administrator agrees with the Hearing Examiner's opinion and recommendation to affirm the disapproval of California's State Plan Amendment 83-14. Accordingly, the Recommended Decision is hereby adopted in all respects not inconsistent with this decision.

The proper and applicable income limitation with respect to a family of two adults, eligible for protection under the Medicaid program, is governed by § 1903(f) of the Social Security Act, as amended [42 USC 1396(b)[*sic*]]. Other than for its exceptions, the language of § 1903(f)(B)(i) is plain and unequivocal:

> "the applicable income limitation with respect to any family is the amount determined, in accordance with standards prescribed by the Secretary, to be equivalent to 133⅓ percent of the highest amount which would ordinarily be paid to a family of the same size . . . under the plan of the State approved under Part A of title IV of this Act."

The regulation implementing the statute is 42 CFR 435.1007. Subsection (a)(1) is fully as clear as the statute:

> "(1) For couples and families of two or more, 133⅓ percent of the highest money payment that would ordinarily be made under the State's AFDC plan to a family of the same size without income and resources. If the State's AFDC plan specifies a maximum family size beyond which there is no increase in benefits, the medically needy income levels for families whose size exceeds that maximum will be determined by adding an amount for each family member over the maximum size. These amounts must be reasonably related to the amounts by which the State's AFDC plan increases benefits for additional family members in families below the maximum size."

Regardless of the possible greater maintenance needs of a two-adult family as opposed to an AFDC family of two (one child, one adult), the statute provides for a single MNIL for a family of two. That limit is 133 ⅓% of the maximum payment ordinarily made under the State's AFDC plan to a family of the same size without income and resources. Despite confusion over the term "reasonably related" (Intervenor's Exhibit 4) the regulation is absolutely clear regarding a family of two.

Affected parties in this matter have argued that recent legislation has interpreted or changed the rule at § 1903(f). Specifically, § 1902(a)(10)(C)(i)(III) of the Social Security Act (SSA), as amended by the Tax Equity and Fiscal Responsibility Act of 1982, [42 USC 1396(a)[*sic*]], is seen to establish a "single standard rule." At § 137 of TEFRA, the law changed the SSA § 1902(a) to require state plans to include description of the single standard for determining income and resource eligibility for all groups. This posi-

tion is the foundation for the related argument that 1984 legislation provided a moratorium on sanctions applying the TEFRA provision. Under this theory, HCFA is barred from disapproving the State's plan amendment in this proceeding.

This analysis has been closely considered, however, the Administrator finds that the 1982 legislation did not change the impact of § 1903(f) of the SSA. The Act as it existed before 1982 provided for payments under but one qualifying MNIL in each State for a family of any particular size. TEFRA did not change this, although it has impact elsewhere. Therefore, the subsequent 1984 legislated moratorium on action under the TEFRA provision does not foreclose action based upon 1903(f) of SSA.

Even if the 1983 Deficit Reduction Act were interpreted to affect § 1903(f), the moratorium does not bar these proceedings. The language of DRA § 2373(c) is specific. The Secretary is prohibited from taking sanctions (such as compliance, disallowances, penalties of other regulatory action) against States during the specified moratorium period where the States' approved Medicaid plans contain less restrictive income or resource methodologies that would otherwise be prohibited under § 1902(a)(10)((C)(i)(III). The moratorium does not require prospective approval of new plan amendments which in any respect violate the Act under TEFRA at § 1902(a) or 1903(f). The DRA refers clearly to a "State's plan under title XIX of the Social Security Act being determined to be in violation . . ." This explicit category does not include proposed State plan amendments that have not been approved under title XIX of the Act.

Considerable attention in the pleadings and at the hearing focused upon a publication which appears as a section in the Regional Office Manual (ROM). The document addresses the legal area at issue in this controversy and purports to approve a separate MNIL for adult couples. The document is dated prior to June 1979, and refers to an

earlier policy information question (PIO[*sic*]). During that period, § 1903(f) of SSA and the related implementing provisions of the Act cited by the Hearing Examiner were in force. The ROM section is patently contrary to the statute and was, therefore, invalid from its origination.

The State's alleged reliance upon the invalid Manual provision is, accordingly, irrelevant to the controversy to be decided here. The State and the Intervenors have made much of the publication and communications about the Manual provision. However, actual reliance was never established and it appears from the "departmental analysis" of the State's legislation enacting the proposed amendment (Exhibit 6-2 and 6-03 to the Deposition at Intervenors' Exhibit 15) that the author advising legislators was aware of the low order of significance to be attached to the ROM section ("transmittal"). Nevertheless, even had there been actual reliance, any potential HCFA liability could not require statutory violations, since the Secretary is bound to follow the direction of Congress. Further, the nature of that liability is not at issue here.

Concerning the Intervenor's objection to sanctions imposed prior to the State's having an opportunity to amend, the Hearing Examiner held that the issue was not before him. These proceedings arise under 45 CFR 201.4 and specific procedures at § 213. While sanctions associated with compliance are specifically considered in the hearings discussed at § 201.6, only the approval or disapproval of a proposed state plan is at issue here. The difference in these hearings is obvious and it follows that sanctions will be placed only when the State is found to be out of compliance. Since a compliance question is not raised here, the substance of the Society's objection is not a part of this decision.

Because of its provisions for separate MNILs for adult couples, the California State Plan Amendment 83-14 is found to be in violation of the statutory provisions identified in the Hearing Examiner's "Recommended Decision." For this reason this proposed amendment is disappoved.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: Jan. 30, 1985

/s/ CAROLYN K. DAVIS, PH.D.,
Carolyne K. Davis, Ph.D.,
Administrator
Health Care Financing
Administration

APPENDIX G

Section 1903(f) of the Social Security Act, 42 U.S.C. 1396b(f), provides in relevant part:

> **Limitation on Federal participation in medical assistance.**
>
> (1)(A) Except as provided in paragraph (4), payment under the preceding provisions of this section shall not be made with respect to any amount expended as medical assistance in a calendar quarter, in any State, for any member of a family the annual income of which exceeds the applicable income limitation determined under this paragraph.
>
> (B)(i) Except as provided in clause (ii) of this subparagraph, the applicable income limitation with respect to any family is the amount determined, in accordance with standards prescribed by the Secretary, to be equivalent to 133⅓ percent of the highest amount which would ordinarily be paid to a family of the same size without any income or resources, in the form of money payments, under the plan of the State approved under part A of title IV of this Act [42 USC §§ 601 et seq.]
>
> (ii) If the Secretary finds that the operation of a uniform maximum limits payments to families of more than one size, he may adjust the amount otherwise determined under clause (i) to take account of families of different sizes.

* * * * *

Section 2373(c)(1) of the Deficit Reduction Act of 1984, Pub. L. No. 98-369, 98 Stat. 494 provides:

> (1) The Secretary of Health and Human Services shall not take any compliance, disallowance, penalty, or other regulatory action against a State during the moratorium period described in paragraph (2) by reason of such State's plan under title XIX of the Social Security Act being determined to be in viola-

tion of [42 U.S.C. 1396a(a)(10)(C)(i)(III)] of such Act on account of such plan's having a standard or methodology which the Secretary interprets as being less restrictive than the standard or methodology required under such section.

* * * * *

Section 137(b)(8) of the Tax Equity and Fiscal Responsibility Act of 1982, 42 U.S.C. 1396a(a)(10)(C)(i)(III), provides:

Contents. A State plan for medical assistance must –

* * * * *

(10) provide –

* * * * *

(C) that if medical assistance is included for any group of individuals described in section 1905(a) [42 U.S.C. § 1396d(a)] who are not described in subparagraph (A), then –

(i) the plan must include a description of (I) the criteria for determining eligibility of individuals in the group for such medical assistance, (II) the amount, duration, and scope of medical assistance made available to individuals in the group, and (III) the single standard to be employed in determining income and resource eligibility for all such groups, and the methodology to be employed in determining such eligibility, which shall be the same methodology which would be employed under the supplemental security income program in the case of groups consisting of aged, blind, or disabled individuals in a State in which such program is in effect, and which shall be the same methodology which would be employed under the appropriate State plan (described in subparagraph (A)(i)) to which such group is most closely categorically related in the case of other groups;

42 C.F.R. 435.811 (1983) provides:

Medically needy income standards: General requirements.

To determine eligibility of medically needy individuals, a Medicaid agency must use an income standard under this subpart that is—

(a) Based on family size;

(b) Uniform for all individuals in a covered group;

(c) For FFP purposes, not in excess of 133⅓ percent of the highest money payment that ordinarily would be made in the State AFDC program to an individual or a family of comparable size (see § 435.1007); and

(d) Reasonable (see § 435.812).

* * * * *

42 C.F.R. 435.1007 (1983) provides:

Medical needy.

(a) FFP is available in expenditures for services provided to medically needy recipients whose annual income after deductions specified in § 436.831(a) and (c) and § 436.832 does not exceed the following amounts, rounded to the next higher multiple of $100;

(1) For couples and families of two or more, 133⅓ percent of the highest money payment that would ordinarily to be made under the State's AFDC plan to a family of the same size without income and resources. If the State's AFDC plan specifies a maximum family size beyond which there is no increase in benefits, the medically needy income levels for families whose size exceeds that maximum will be determined by adding an amount for each family member over the maximum size. These amounts must be reasonably related to the amounts by which the State's AFDC plan increases benefits for additional family members in families below the maximum size.

(2) For individuals, 133⅓ percent of an amount reasonably related to the highest money payment which would ordinarily be made under the State's AFDC plan to a family of two without income and resources.

Section 14005.12 of the Cal. Welf. & Inst. Code (West Supp. 1986) provides, in relevant part, as follows:

Income levels for maintenance

(a) For the purposes of Sections 14005.4 * * * and 14005.7, the department shall establish the income levels for maintenance need at the lowest levels that reasonably permit medically needy persons to meet their basic needs for food, clothing, and shelter, and for which federal financial participation will still be provided under Title XIX of the federal Social Security Act. It is the intent of the Legislature that the income levels for maintenance need for medically needy aged, blind, and disabled adults, in particular, shall be based upon amounts that adequately reflect their needs.

(b) In the case of a single individual, the amount of the income level for maintenance per month shall be 80 percent of the highest amount that would ordinarily be paid to a family of two persons, without any income or resources, under subdivision (a) of Section 11450, multiplied by the federal financial participation rate.

(c) In the case of a family of two adults, the income level for maintenance per month shall be the highest amount that would ordinarily be paid to a family of three persons without income or resources under subdivision (a) of Section 11450, multiplied by the federal financial participation rate.

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Supreme Court, U.S.
FILED
JAN 30 1987
JOSEPH F. SPANIOL, JR.
CLERK

No. 86-863

(7)

In The
Supreme Court of the United States
October Term, 1986

Otis R. Bowen, Secretary of Health and Human Services,
Petitioner,

v.

Kenneth Kizer, Director of the California Department of Health Services, et al.,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

RESPONDENTS' BRIEF IN OPPOSITION

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QUESTIONS PRESENTED

1. Whether, when Congress has specifically permitted states to employ a separate and higher Medicaid income standard for adult couples than that used for a family of a parent and child during a temporary moratorium period, the Secretary may refuse to approve California's Medicaid state plan amendment establishing such a standard?

2. Whether California could properly rely upon an interpretative guideline promulgated by HHS' Health Care Financing Administration in setting its Medicaid income standard for adult couples, when HHS' regulations contemplate that states may rely upon such guidelines, and when the guideline is consistent with the language of Title XIX of the Social Security Act, and is reasonably related to the purposes of the Act?

PARTIES TO THE PROCEEDING

The Director of the California Department of Health Services is now Kenneth Kizer, M.D. The remaining parties are set forth in the Petition.

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STATUTORY AND REGULATORY PROVISIONS INVOLVED

The relevant portions of § 1902(a) of the Social Security Act ("the Act"), 42 U.S.C. § 1396a(a), of § 1903(f) of the Act, 42 U.S.C. § 1396b(f), of 42 C.F.R. § 435.1007, and of California Welfare and Institutions Code § 14005.12 are set out in the Appendix to the Petition. (Pet. App. 46a-49a). The Petition omits relevant portions of § 2373(c) of the Deficit Reduction Act of 1984, Pub. L. No. 98-369, 98 Stat. 1112 ("DEFRA"). That section of DEFRA, in its entirety, together with 45 C.F.R. § 201.3(d), and HHS' Regional Office Manual § 2572-D, are set out at App. 1-2, 7-10, *infra*.

———o———

STATEMENT OF THE CASE

The statement of the case in the Secretary's Petition is incomplete in several respects. First, the Petition does not describe the events leading up to the enactment of California Welfare & Institutions Code § 14005.12(c). Second, the Petition does not discuss HHS' initial reliance upon the "single standard" requirement adopted in the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA") as the basis for its disapproval of California's state plan amendment. Third, the Petition does not describe Congress' hostile reaction to HHS' position, which culminated in passage of § 2373(c) of DEFRA ("the moratorium provision"). Finally, the Petition simply omits any mention of the DEFRA Conference Committee's report on that provision, (App. 3-6), which makes clear that, until Congress has had "an opportunity to study and legislate on the mat-

ter," (App. 5), states are expressly permitted to establish adult couple MNILs, as California has done here. Respondents therefore supplement Petitioner's statement of facts.

A. California's Adoption of the Adult Couple MNIL

As set forth in the Petition, Title XIX of the Social Security Act, which established the Medicaid program, requires participating states to provide benefits to the "categorically needy," and permits them the option of providing benefits to the "medically needy." (Pet. at 2-3). California has elected to include the medically needy in its Medicaid program (known as "Medi-Cal").

States must establish income limits to be used in determining Medicaid eligibility for the medically needy. These standards, known as "medically needy income levels" or "MNILs", set the amount of income allotted to an individual or family for non-medical necessities such as food, clothing, and shelter, according to family size. *See* California Welfare and Institutions Code § 14005.12. The remainder of the family's income is its "share of cost". Each month, medically needy individuals or families must incur medical expenses in an amount equal to their share of cost before Medicaid will pay the remaining medical bills incurred during the month. Welfare and Institutions Code §§ 14005.9, 14054.

Until June, 1982, California had a special income deduction which permitted medically needy aged, blind, and disabled people to keep as much income as SSI recipients to meet their non-medical needs. The Legislature repealed this deduction as part of an extensive Medi-Cal reform

package. AB 799, 1982 Stats. Ch. 328, § 8. As a result, the MNIL for two persons was set at $544. In contrast, categorically needy aged, blind, and disabled couples on SSI were, at the time, receiving $838 per month to meet their non-medical needs. (A.R. 336).[1] For the first time, as a condition of receiving Medi-Cal, medically needy pensioners and blind and disabled people were required to live on amounts far below that allotted to SSI recipients.

During the early part of 1983, the California Legislature's Assembly Committee on Aging and Long Term Care held public hearings on the effect of the AB 799 changes in the Medi-Cal program. The testimony at those hearings centered, in large part, on the impact of the sharp increase in the share of cost. Aged and disabled recipients and their advocates testified that sick people were unable to afford both their non-medical expenses and their expenses for outpatient care, such as doctor's visits and prescription drugs. Testimony indicated that the increase in the share of cost was exacerbating widespread malnutrition among the elderly, and, in some cases, was causing unnecessary institutionalization. (A.R. 337-338, 611-822).

As a result of the public outcry concerning the impact of the new income standards, (A.R. 338-39), the Legislature adopted a new formula to determine the MNIL for adult couples, to ensure "that the income levels for maintenance need for medically needy aged, blind, and disabled adults, in particular, shall be based upon amounts that adequately reflect their needs." Welfare & Inst. Code

---

[1] The reference is to the Administrative Record, filed in the court below.

§ 14005.12(a),(c), as amended by 1983 Stats. Ch. 323, § 124.6. (Pet. App. 49a). The new adult couple MNIL of $709 per month (A.R. 41), was based upon Section 2572-D of the Regional Office Manual ("ROM") published by HHS' Health Care Financing Administration ("HCFA") (App. 7-10). ROM 2572-D provided that states may establish adult couple MNILs, set as high as 133⅓% of the AFDC grant for a family of three, "in order to effectively acknowledge the greater maintenance needs of an adult as opposed to those of a child." (App. 9).

B. HHS' Disapproval of ROM 2572-D and Congress' Reaction

While California's legislation was still pending, HHS' Regional Office in San Francisco, aware that the State was relying upon ROM 2572-D, requested guidance from HCFA's Bureau of Eligibility, Reimbursement and Coverage ("BERC") concerning the validity of the ROM provision.[2] (A.R. 127, App. 11-12). The Regional Office suggested that the ROM provision was no longer valid in light of § 1902(a)(10)(C) of the Act, 42 U.S.C. § 1396a(a)(10)(C)(i)(III), as amended by § 137(b)(8) of the Tax Equity and Fiscal Responsibility Act of 1982, P.L. 97-248 ("TEFRA"). That provision, (Pet. App. 47a), requires state plans to describe "the single standard to be employed in

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[2] The BERC "reviews existing policy and develops new policy" concerning eligibility for the Medicaid program. CCH Medicare & Medicaid Guide, 1985 Transfer Binder ¶ 34450 at 9236. The Regional Office was required to seek BERC's guidance by 45 C.F.R. § 201.3(b) ("State plan material on which the regional staff has questions concerning the application of Federal policy is referred with recommendations as required to the central office for technical assistance.")

determining income and resource eligibility for all such [medically needy] groups."

In April 1983, in a document entitled "Policy Information For All Regions", the Director of the BERC advised the Regional Administrator: "Establishing different medically needy levels that would vary by family composition, would in effect, result in application of more than a single standard for a group", and would thereby violate TEFRA. (A.R. 131, App. 13-14). The Regional Office, in turn, advised the California Department of Health Services of HCFA's interpretation. (A.R. 139, App. 15-16).

Despite HCFA's position, the California Legislature adopted the adult couple MNIL, and the Department of Health Services subsequently submitted its state plan amendment to HHS. In the meantime, Congress had been alerted to HCFA's new policy regarding the validity of ROM 2572-D. In October, 1983, the House Energy and Commerce Committee reported a bill to the House of Representatives which permitted states to adopt an adult couple MNIL as California proposed. H.R. 4136, 98th Cong., 1st Sess. § 211.

The Committee both approved the substance of ROM 2572-D, and disagreed with HHS' position that TEFRA required its reversal:

> The Committee is at a loss to understand why the Department has decided to alter its policy. . . . The policy is sound. . . . The Committee bill makes clear that [TEFRA's] single standard requirement does not justify a rejection of the valid 1979 policy with respect to two medically needy adults.

H.R. Rep. 98-442, Pt. 1, 98th Cong., 1st Sess. 51 (1983) (App. 18, 19). Recognizing that the literal language of TEFRA would preclude states from maintaining a different income standard for medically needy families of two adults than is applicable to a family of a parent and child, the Committee stated its intent to create a limited exception to TEFRA: "In short, the Committee amendment would relax the single standard requirement only in the limited circumstance" in which a state adopts an adult couple MNIL. *Id.* at 52 (App. 20). The House passed the Committee's provision in H.R. 5394, 98th Cong., 2d Sess. § 361 (1984) (App. 17).

C. The DEFRA Moratorium

When H.R. 5394 went to conference with the Senate, the Conference Committee declined to enact the exception to TEFRA's single standard requirement contained in the House bill, because it was too limited. The Committee was concerned that HHS' "overly literal" reading of TEFRA had created "grave administrative problems for the States" and had "threaten[ed] to cause great hardship for applicants and beneficiaries" in a number of respects, including but not limited to adult couple MNILs. H.R. Rep. 98-861, 98th Cong., 2d Sess. 1367-68 (1984) (App. 4-5). Therefore, the Committee determined to enact a broader but time-limited moratorium, during which the states would be permitted to adopt a variety of "less restrictive" standards and methodologies for their medically needy programs than those required by a strict reading of TEFRA. Accordingly, in § 2373(c)(1) of the Deficit Reduction Act of 1984, ("DEFRA"), P.L. 98-369, 98 Stat. 1112, Congress forbade the Secretary from taking "any compliance, dis-

allowance, penalty, or other regulatory action" against a state during a moratorium period of approximately 30 months because the state uses a standard or methodology which the Secretary considers to violate TEFRA's "single standard" or "same methodology" requirement. (App. 1).

Although the Conference Committee rejected the House provision, it approved the use of adult couple MNILs. Indeed, as the committee report reflects, one of Congress' purposes in enacting § 2373(c) was to prohibit the Secretary from taking any regulatory action against a state based on its use of an adult couple MNIL during the moratorium:

> Section 137[(b)](8) of the Tax Equity and Fiscal Responsibility Act, P.L. 97-248 (TEFRA), amended the Medicaid statute to clarify that [in the Omnibus Budget Reconciliation Act of 1981 ("OBRA"), P.L. 97-35], Congress did not intend to change the policies governing the income and resource standards and methodologies for determining eligibility of the medically needy from those in effect before OBRA. This amendment provided in part that the methodology to be used in determining income and resource eligibility for the medically needy must be the "same methodology" used under the relevant cash assistance program.
>
> . . . [I]t is the understanding of the conferees that the Department has implemented this provision in an overly literal fashion, without taking into account the intent of the TEFRA clarification.
>
> *For example, . . . the Department has taken the position that the "single standard" requirement of the TEFRA amendment prohibits States from establishing less restrictive medically needy income levels for single adults and couples because this would result in differ-*

> *ences in medically needy income levels among groups of the same family size depending on relative numbers of adults and children.*
>
> The Department's overly restrictive interpretation of section 137[(b)](8) of TEFRA has posed grave administrative problems for the States and threatens to cause great hardship for applicants and beneficiaries. . . . The conferees have therefore decided to impose a moratorium on the Department's implementation of the TEFRA amendment until the Congress has an opportunity to study and legislate on the matter. (App. 4-5).

Thus, in DEFRA, Congress expressly permitted the states to establish separate medically needy MNILs for adult couples, at least "until the Congress has an opportunity to study and legislate on the matter." (App. 5).

D. The Secretary's Change of Pcsition and The Ninth Circuit's Reaction

In January, 1985, six months after enactment of DEFRA, HCFA's Administrator issued a decision disapproving California s adult couple MNIL. (Pet. App. 38a). The decision avoided reliance upon TEFRA, but rather rested upon § 1903(f) of the Act. 42 U.S.C. § 1396b(f), and the regulation implementing that provision, 42 C.F.R. § 435.1007. (Pet. App. 46a, 48a). Nevertheless, the agency's underlying position was the same as that which had been before Congress: "Regardless of the possible greater maintenance needs of a two-adult family as opposed to an AFDC family of two (one child, one adult), the statute provides for a single MNIL for a family of two." (Pet. App. 42a).

The Ninth Circuit unanimously rejected HHS' attempt to dress the same emperor in new clothes: "[T]he Cali-

fornia plan amendment raises exactly the kind of problem which Congress addressed by establishing a moratorium on HHS implementation of the TEFRA 'single standard' provision." (Pet. App. 17a). Citing the Conference Committee report, the court concluded: "Congress intended the DEFRA moratorium to apply in precisely this situation." (*Id.*)

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REASONS FOR DENYING THE WRIT

I. BECAUSE THE COURT OF APPEALS' DECISION RESTS UPON A STATUTE WHICH IMPOSES A TEMPORARY MORATORIUM, THIS CASE PRESENTS NO IMPORTANT QUESTION OF LAW WHICH NEED BE DECIDED BY THIS COURT

The Secretary's Petition focuses almost exclusively upon the Court of Appeals' holding that ROM 2572-D has legislative effect. However, the court did not rest its judgment only upon that ground, but also relied upon DEFRA's moratorium provision as "an additional, independent reason for reversal." (Pet. App. 16a). Thus, the issue primarily discussed in the Petition is not squarely presented to this Court, since the case can be resolved on the basis of the DEFRA issue. Moreover, the Court of Appeals' DEFRA ruling does not present questions worthy of this Court's review for two reasons: First, because the DEFRA moratorium is, by its terms, temporary; and second, because the Court of Appeals' application of DEFRA is correct on the merits.

A. Congress Enacted the DEFRA Moratorium as a Temporary Measure, and Has Expressed Its Intent to Revisit the Issue of Adult Couple MNILs

When Congress rejected the Secretary's "overly literal" reading of TEFRA in § 2373(c) of DEFRA, it did not intend to close the subject. Rather, Congress sought a temporary solution to the "grave administrative problems for the States" and the threatened "great hardship for applicants and beneficiaries" which had resulted from HHS' "overly restrictive interpretation". (App. 4-5). It therefore enacted a moratorium on the Secretary's enforcement of TEFRA's "single standard" and "same methodology" requirements. § 2373(c)(1) (App. 1). During the moratorium, states are free to establish adult couple MNILs and other "less restrictive" standards and methodologies than those required under a strict reading of TEFRA, limited only by Congress' expectation that they "will be reasonable." (App. 6).

Congress' purpose in enacting the moratorium was to provide itself with "an opportunity to study and legislate on the matter," so that it could fashion a permanent solution to the "unintended, and in some cases, undesirable consequences" of the Secretary's TEFRA enforcement policy. (App. 5). To that end, Congress directed the Secretary to furnish it with a report by July 18, 1985 (twelve months after enactment of DEFRA), "with respect to the appropriateness, and impact on States and recipients of medical assistance, of applying standards and methodologies utilized in cash assistance programs [to the medically needy], and any recommendations for changes in such requirements." § 2373(c)(3) (App. 1). Anticipating that

the Secretary's report would serve as a catalyst for future legislation, Congress also gave itself an additional period to act before the Secretary could again begin his enforcement of TEFRA. Thus, the moratorium established under § 2373(c)(1) ends 18 months after the Secretary submits his report. § 2373(c)(2) (App. 1).

Despite the concerns voiced in the Secretary's Petition as to the consequences of the Court of Appeals' DEFRA ruling, he has not yet submitted the report which Congress mandated. His report is now a full eighteen months overdue. Had he submitted a timely report, Congress might well have already resolved the issues presented in the Petition.

Rather than becoming involved in interpreting § 2373(c) of DEFRA at this juncture, the Court should defer to Congress, which has stated its intent further to address the issue of adult couple MNILs, and indeed, an entire range of issues arising from TEFRA's "single standard" and "same methodology" rules. The Secretary has Congress' ear, but has not spoken. His remedy, if one is due, lies there, rather than with this Court.

B. The Court of Appeals' DEFRA Holding is Correct

The Secretary argues that the court's DEFRA holding is "contrary to clearly expressed congressional intent." (Pet. at 19). However, he does not discuss—or, indeed, even mention—the Conference Committee report, where Congress clearly indicated that § 2373 was intended, *inter alia,* to permit states to maintain adult couple MNILs during the moratorium period. (See pp. 7-8,

supra.) Resting its judgment squarely on the committee report, the Court of Appeals ruled that "Congress intended the DEFRA moratorium to apply in precisely this situation." (Pet. App. 17a-18a). The court followed Congress' intent to the letter.[3]

Rather than focusing upon the report of the Conference Committee and Congress' evident purpose in enacting § 2373(c), the Secretary attempts to show that the DEFRA moratorium is inapplicable here. His hypertechnical arguments, however, are inconsistent with Congress' expressed intent, and are without merit.

First, although he never raised the argument below, the Secretary contends here that TEFRA's requirement that states use a "single standard" and its requirement that states apply the "same methodology" as that used in the related cash assistance program, both of which were the subject of the DEFRA moratorium, are the same. The Secretary claims that the TEFRA amendment was concerned solely "with determining what resources are to be regarded as income for purposes of Medicaid eligibility." (Pet. at 18). He implies that, because California's plan amendment did no more than set the income standard for medically needy adult couples, it is outside the scope both of TEFRA and of the DEFRA moratorium.

This argument ignores the language of TEFRA itself. Section 1902(a)(10)(C), as amended (Pet. App. 47a),

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[3] The moratorium provision originated in the Conference Committee. Thus, the Committee's report is certainly dispositive of Congress' intent—indeed, it is the only legislative history available.

does address the methodology which states must use in determining how much income is available to a Medicaid recipient—the question which was the subject of this Court's opinion in *Atkins v. Rivera*, 477 U.S. —, 91 L.Ed.2d 131, 106 S.Ct. 2456 (1986). But, in addition, the statute separately requires states to use a "*single standard*" for all medically needy groups. It is simply not the case, as the dissent to denial of an en banc hearing below contended, that these terms are "synonomous." (Pet. App. 32a, n.3). *See Camacho v. Perales*, 786 F.2d 32, 43-44 (2d Cir. 1986) (discussing the difference between the two terms);[4] *Morris v. Morrow*, 783 F.2d 454, 461-62 (4th Cir. 1986) (holding that the rule at issue there was a methodology, not a standard). Indeed, the Secretary himself recognized in the preamble to 1981 regulation changes that medically needy income levels are "standards", while rules regarding treatment of income and resources are "methodologies." *Id.* at 462.

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[4] There is no merit to the Secretary's suggestion that the Court of Appeals' interpretation of DEFRA is at odds with that of the Second Circuit in *Camacho, supra*. There, in a case brought by Medicaid recipients to invalidate a *more* restrictive methodology than that used in the SSI program, the State argued that its methodology was in some but not all respects, less restrictive, and therefore was permitted under DEFRA. *Id.* at 42. The Secretary was not a party. The court refused to apply the DEFRA moratorium, both because it had been enacted after the District Court's decision, and because the provision "is too sketchy in detailing Congress's present thinking to be invoked to govern the rights of the parties here." *Id.* The parties in this case, however, are precisely those to whom Congress addressed the moratorium: The Secretary on the one hand, and the State on the other. Moreover, the history of the moratorium provision leaves no doubt but that states have authority to adopt adult couple MNILs, as California proposed here. The moratorium provision governs.

This case plainly concerns "the State's decision as to what income level will be linked with a particular household size", i.e., "the setting of a standard" as Congress used the word in TEFRA. *Camacho, supra,* 786 F.2d at 44. Although TEFRA literally requires a "single standard," DEFRA nevertheless specifically permits states to establish adult couple MNILs during the moratorium.

Second, the Secretary contends that, in enacting the DEFRA moratorium, Congress' sole intent was to override regulations issued in 1981. (Pet. at 18). He therefore argues that DEFRA is irrelevant, because this case turns upon 42 C.F.R. § 435.1007, which was promulgated in 1978. This argument ignores what Congress said it was doing: *In the Conference Committee report, Congress said that it intended to permit states to establish adult couple MNILs during the moratorium period.* Congress explicitly repudiated the Secretary's position that states could not do so because they would be establishing more than one income standard for families of the same size—a position which the Secretary adopted after 1981, and which rested upon the "single standard" language of TEFRA. (See pp. 4-5, *supra*).

Third, the Secretary argues that, because his predecessor did not rely upon TEFRA's single standard requirement in her final decision, he is not "exercis[ing] a power affected by the moratorium, [so that] the moratorium is totally irrelevant." (Pet. at 19). Again, the Secretary fails to discuss the Conference Committee report, which forbade the Secretary from "proceed[ing] with the imposition of any sanctions, or otherwise suggest[ing] to the States" that they may not use less restrictive standards than those required under a literal

reading of TEFRA. (App. 5-6). The Secretary would have this Court ignore the fact that Congress gave adult couple MNILs as an example of the "less restrictive" standards which the Secretary had forbidden, and which Congress intended to permit. The power which the Secretary seeks to exercise here—to forbid California from maintaining an adult couple MNIL, upon pain of fiscal sanctions[5]—is precisely the power which Congress intended to deny him when it enacted the moratorium.

Finally, the Secretary contends that the Ninth Circuit's decision would cost the federal government $50 million annually, and that the court's DEFRA holding therefore merits review. There is simply nothing in the record which supports the Secretary's assertion, nor is there any support for his cost estimate in reality. The California Department of Finance has estimated that the adult couple MNIL will increase the State's Medicaid expenditures by slightly less than $5 million annually, with half of that sum coming from state funds. Moreover, Congress contemplated this limited increase in Medicaid expenditures when it enacted the DEFRA moratorium.

Thus, the Secretary's contentions with respect to the Court of Appeals' DEFRA holding are without merit. That holding is consistent with the language and intent of the DEFRA moratorium. This case raises no important issues of law for this Court's review.

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[5] In the case of "an unapprovable change in the approved State plan," the Administrator of HCFA may withhold federal matching funds from the State. 45 C.F.R. § 201.6(a).

II. THE JUDGMENT RAISES NO IMPORTANT QUESTIONS OF LAW UNDER THE ADMINISTRATIVE PROCEDURE ACT

Because the DEFRA issue is completely dispositive of this case, this Court need not decide the questions raised in the Petition as to the validity of ROM 2572-D and the degree of deference which must be paid to that informally promulgated regulation—questions which DEFRA has robbed of any vitality. The broader issue of whether an informally promulgated regulation can ever be given "legislative effect" must await a case where it is presented "in the context of meaningful litigation." *The Monrosa v. Carbon Black Export, Inc.*, 359 U.S. 180, 184 (1959).

Respondents do wish, however, to address a few words to the Secretary's alarmist discussion of the Court of Appeals' holding regarding ROM 2572-D. In his Petition, the Secretary complains that, by giving the ROM provision legislative effect, the decision below "will wreak havoc on federal agencies and on the public . . . ." (Pet. at 16-17). This case does not warrant such overblown rhetoric.

The Ninth Circuit's decision arises from a unique set of circumstances unlikely to recur. Although it is now a year old, it has never been cited outside of the Ninth Circuit, and even that court appears to have limited the decision to its facts. Thus, the decision has not had any impact, much less the disastrous influence which the Secretary assigns to it. Moreover, there is plainly no conflict between the decision below and that of any other court of appeals. Finally, if certiorari were granted,

the Court could affirm the judgment on the basis of settled principles of administrative law. For these reasons, even absent DEFRA, the decision below raises no important questions for review.

A. Because of the Unique Features of This Case, The Court of Appeals' Opinion as to the Legislative Effect of ROM 2572-D Does Not Raise Important Issues of Law

The Secretary greatly exaggerates the import of the Court of Appeals' holding that ROM 2572-D is a legislative regulation.[6] The court recognized that "agency office manuals generally do not prescribe legislative rules with binding effect," (Pet. App. at 11a), but viewed this as an exceptional case for several reasons: The regulation is directed at states, rather than individuals; it provides guidance to states in establishing their MNILs; it was promulgated pursuant to a statute which delegates to the Secretary authority to prescribe standards to be used for that purpose; Congress had not required compliance with the Administrative Procedure Act's notice and comment provisions; and neither the State nor the public had complained of or was harmed by the lack of public participation. (Pet. App. 11a-16a) It is unlikely that this same combination of factors, each of which was a *sine qua non* of the decision, will recur.

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[6] No party ever urged that ROM 2572-D is a legislative regulation. Rather, all conceded that the provision is an interpretative guideline. The parties differed only as to its substantive validity. The Court of Appeals thus reached its conclusion without the benefit of briefing on the subject.

A recent Ninth Circuit case illustrates the limited reach of the decision below. In *Linoz v. Heckler*, 800 F.2d 871 (9th Cir. 1986), the court considered the validity of a provision of HHS' Carrier's Manual, an informally promulgated compilation of instructions prepared by the Secretary for private insurance carriers who act as intermediaries in the Medicare program. The provision at issue, which concerned Medicare coverage of ambulance service, resulted in denial of Medicare reimbursement to the plaintiffs. Although the *Linoz* court cited the decision below for the general distinction between "interpretative" and "substantive" rules, *id.* at 877, and held that the manual provision was "substantive", it did not hold that the provision had the force and effect of law. Rather, the court held that the provision was invalid because it had not been promulgated pursuant to the rulemaking provisions of the APA. *Id.* at 877-878.

The APA analysis used in this case was inapplicable in *Linoz*, as it will be inapplicable in virtually every case, because the critical factors present here were absent there: The Carrier's Manual provision which the *Linoz* plaintiffs challenged was not addressed to the states, and was not promulgated under an express grant of authority to make standards, *id.* at 877, n.10; moreover, the *Linoz* plaintiffs were harmed by the Secretary's failure to provide public notice and comment, and complained on that basis. Thus, *Linoz* indicates that even the Ninth Circuit will in future limit the decision below to its facts. There is no indication that the APA holding in this case will "wreak havoc

on federal agencies and on the public," as the Secretary claims. (Pet. at 16-17).[7]

B. The Judgment Can Be Explained on Alternative Grounds Which Do Not Raise Important Questions of Law

"[T]his Court reviews judgments, not opinions, . . ." *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842 (1984). Although the court below gave ROM 2572-D "legislative effect", it could well have rested its judgment upon the ordinary deference which this Court and the courts of appeals have given similar regulatory material. Had it done so, the only question would have been whether the ROM provision is consistent with the statute and reasonably related to the purposes of Title XIX—a question which the court decided correctly. Because the result would have been the same even if the court's reasoning had been different, this case raises no important questions of law for this Court's review.

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[7] *Vance v. Hegstrom*, 793 F.2d 1018 (9th Cir. 1986), is the only case to date which followed the APA analysis used in the decision below. In *Vance*, the *Secretary* argued, and the court agreed, that it was required to give an HHS "directive" legislative effect. (HHS Reply Br. in No. 85-4050 at 6-7. *See also* HHS Opening Br. at 34-39 (arguing that the directive must be given "great weight and substantial deference if not 'legislative effect.'" (*Id.* at 39)). However, because the court invalidated the directive on the ground that it was inconsistent with Title XIX, plaintiffs did not seek review in this Court. Nor did the Secretary, although *Vance* raises the issue of the degree of deference owing to informally promulgated regulations far more squarely than does this case.

1. California Could Properly Rely on ROM 2572-D Although It was Not Promulgated in a Formal Rulemaking Proceeding

HHS administers both the Medicaid and the Medicare programs by means of a multitude of informally promulgated instructions and guidelines. The courts have uniformly held that these regulatory materials are entitled to deference, so long as they are consistent with the statute and the agency's regulations. *See, e.g., Charter Peachford Hospital, Inc. v. Bowen,* 803 F.2d 1541, 1546-47 (11th Cir. 1986); *Wisconsin Dept. of Health v. Bowen,* 797 F.2d 391, 397 (7th Cir. 1986), *pet. for cert. filed,* 55 U.S.L.W. 3337 (U.S. Nov. 11, 1986) (No. 86-648); *Sun Towers, Inc. v. Heckler,* 725 F.2d 315, 325 n.16 (5th Cir.), *cert. denied,* 469 U.S. 823 (1984). This Court has specifically sanctioned deference to such interpretations: "[R]ulings, interpretations and opinions . . . do constitute a body of experience and informed judgment to which courts and litigants may properly resort for guidance." *Skidmore v. Swift & Co.,* 323 U.S. 134, 140 (1944).

Indeed, in this case, the Secretary's own regulations specifically instruct states to look to HHS' informally promulgated regulatory materials in formulating their state plans. 45 C.F.R. § 201.3(d) provides: "Guidelines are furnished to assist in the interpretation of the regulations" which will be used in determining whether state plans may be approved. (App. 2). In the court below, the Secretary herself argued that ROM 2572-D was such an "interpretative guideline." (Pet. App. 10a).

Pointing to the foreword to the Regional Office Manual—a document which was never put in evidence—the

Secretary contends that the State should not have relied upon the ROM provision, although it was published in the CCH Medicare & Medicaid Guide, (1980 Transfer Binder ¶30,392 at 9521), along with a variety of other similar interpretations relating to standards for approval of state plans.[8] The Secretary's contention that the ROM was for internal use only, when examined in light of the content of ROM 2572-D and of the Manual's other published guidelines, is truly remarkable. The published interpretations cover a wide variety of subjects of vital interest to the states: Issues regarding state organization and administration of Medicaid plans, (1979-2 Transfer Binder ¶30,124); federal reimbursement for staffing and training costs, (*id.*, ¶30,125); and permissible limitations on the scope of coverage of various services, (*id.*, ¶29,997), to name but a few. The thrust of the Secretary's argument is that HHS can review state plans and decide whether to approve them on the basis of "secret law" which has not been and may not be disclosed to the states. If the Ninth Circuit had so held, that, indeed, would be a ruling which would merit this Court's review. In contrast, the Ninth Circuit's holding that California could rely upon the ROM does not raise an important issue of law.[9]

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[8] The table of contents to the 1980 Transfer Binder lists 21 ROM sections published therein, some with several subparts. Each is introduced by the sentence, "HCFA has issued guidelines reproduced below . . . ." Similarly, the 1979-2 Transfer Binder contains 35 sections of the ROM.

[9] The Petition asserts that ROM 2572-D was eliminated from a 1980 revision of the ROM. (Pet. at 17). Certainly, Congress was not made aware of this revision in 1983-84, when it con-

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2. ROM 2572-D is Consistent with § 1903(f) and With HHS' Regulations

The Secretary insists that ROM 2572-D is invalid because it is inconsistent with § 1903(f) and with 42 C.F.R. § 435.1007. He ignores the fact that the guideline fills a gap in both the statute and the regulation, and is consistent with both.

Section 1903(f)(1)(B)(i), 42 U.S.C. § 1396b(f)(1)(B)(i), provides: "[T]he applicable income limitation with respect to any family is the amount determined, *in accordance with standards prescribed by the Secretary*, to be *equivalent* to 133⅓ percent of the highest amount which would *ordinarily* be paid to a family *of the same size*" under the AFDC program. (Pet. App. 46a). As the Court of Appeals noted, this provision does not contemplate "a mathematical procedure", but allows latitude for the Secretary to develop standards for "equivalent" MNILs. (Pet. App. 7a).[10]

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sidered the validity of ROM 2572-D. Nor is there any evidence of the revision in the record—indeed, the Secretary raised this contention for the first time in his petition for rehearing, and then only in a footnote. (Reh. Pet. at 9 n.3). And as he noted there, HCFA's April, 1983 letter to the Regional Administrator stated that the ROM provision had *not* been repealed. (App. 13-14). That letter correctly recognized that, in order to repeal a "statement of general policy or interpretation of general applicability" such as ROM 2572-D, the agency was required, at a minimum, to publish a notice in the Federal Register. 5 U.S.C. § 552(a)(1)(D). *See Cabias v. Egger*, 690 F.2d 234, 238 n.8 (D.C. Cir. 1982). No such notice has ever been published.

[10] The Secretary contends that he only has limited authority to promulgate standards "establishing the State's determination as to which of its AFDC payment levels for a family of a given

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As HCFA recognized in ROM 2572-D, the statute—and HHS' implementing regulation, which contains the identical language—create an ambiguity with respect to adult couples, because states do not *ordinarily* pay AFDC grants to families of two adults. *See* 42 U.S.C. § 606(b) (AFDC defined as "money payments with respect to a dependent child or dependent children"). A state's AFDC payment level for a family of two is thus based upon the needs of one adult and one child. The ROM properly permitted the states "to effectively acknowledge the greater maintenance needs of an adult as opposed to those of a child" by setting adult couple MNILs. (App. 9). Certainly, this interpretation was well within the Secretary's discretion, and was consistent with the purposes of Title XIX.

Congress approved the Secretary's interpretation when it enacted the DEFRA moratorium. The House explicitly found, and the Conference Committee implicitly assumed that the policy set out in ROM 2572-D was "sound". See pp. 5-8, *supra*. The Conference Committee differed with the House only in its solution to the problem created by TEFRA: The House would have permanently "relax[ed] the single standard requirement only in the limited

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size is the 'highest' that would 'ordinarily be paid' to a family of that size.". (Pet. at 12). There is absolutely no support for this narrow reading in the statute or in its legislative history. Indeed, this Court has recognized that when Congress used language of delegation such as that in § 1903(f), it "conferred on the Secretary exceptionally broad authority to prescribe standards" implementing the Act. *Schweiker v. Gray Panthers*, 453 U.S. 34, 43 (1981).

circumstance'' in which a state adopts an adult couple MNIL (App. 20); the Conference Committee refused permanently to ''relax the single standard requirement'' in this limited respect, but rather proposed a temporary moratorium, during which states are free to adopt a variety of ''less restrictive'' standards and methodologies, including adult couple MNILs. Where, as here, Congress '' 'has ratified [an administrative construction] with positive legislation,' we cannot but deem that construction virtually conclusive.'' *Commodity Futures Trading Comm'n. v. Schor,* 478 U.S. —, 92 L.Ed.2d 675, 690, 106 S.Ct. 3245 (1986).

3. The Decision as to the Validity of ROM 2572-D Raises No Important Issue of Law

Even if this Court were persuaded that ROM 2572-D is inconsistent with § 1903(f) of the Act—a conclusion which Congress precluded in DEFRA—that in itself would not warrant review. No other state has adopted an adult couple MNIL as of this date, and no decision of either a state or federal appellate court is in conflict with that of the court below. Nor is it likely that states will rush to establish such income standards if this Court denies review: Just as California must pay 50% of the increased cost resulting from adoption of its adult couple MNIL, so any state which follows its example must pay part of the cost itself.[11]

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[11] The federal government pays a percentage of each state's Medicaid expenditures, on the basis of the formula set out in 42 U.S.C. § 1301(a)(8). The current percentages, which vary by state, are published at 4 CCH Medicare & Medicaid Guide ¶ 35,908.

Nor is the Court of Appeals' judgment in conflict with any opinion of this Court. Certainly, the judgment does not conflict with this Court's decision in *Schweiker v. Hansen*, 450 U.S. 785 (1981). There, the plaintiff relied upon the doctrine of equitable estoppel because the relief which she sought was contrary both to the clear mandate of the Social Security Act and of HHS' regulations. But a claim based upon an agency's regulations, whether "legislative" or "interpretative", does not raise an issue of estoppel. *See Lyng v. Payne*, 476 U.S. —, 90 L.Ed.2d 921, 931-32, 106 S.Ct. 2333 (1986). *Hansen*, of course, did not preclude the court below from finding that ROM 2572-D is consistent with § 1903(f) and is entitled to deference.

The Secretary's real quarrel here lies not with the Court of Appeals, but with Congress. He complains that the judgment "limits [his] ability to enforce the statutory cap on federal financial participation in Medicaid." (Pet. at 19). But, although DEFRA, in its broad outlines, may have been "a deficit reduction measure", (*id.*), in the moratorium provision, Congress expressly permitted the states to adopt "less restrictive" standards and methodologies, including adult couple MNILs, so long as they are "reasonable", notwithstanding the fiscal implications. The Secretary should address his comments to Congress, rather than to this Court. There is no reason for this Court to grant review.

———o———

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted,

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Attorney General of the
State of California
RALPH JOHNSON*
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* Counsel of Record

January, 1987

APPENDIX A

Section 2373(c) of the Deficit Reduction Act of 1984, Pub.L. 98-369, 98 Stat. 1112, provides:

> (1) The Secretary of Health and Human Services shall not take any compliance, disallowance, penalty, or other regulatory action against a State during the moratorium period described in paragraph (2) by reason of such State's plan under title XIX of the Social Security Act being determined to be in violation of section 1902(a)(10)(C)(i)(III) of such Act on account of such plan's having a standard or methodology which the Secretary interprets as being less restrictive than the standard or methodology required under such section.
>
> (2) The moratorium period is the period beginning on the date of the enactment of this Act and ending 18 months after the date on which the Secretary submits the report required under paragraph (3).
>
> (3) The Secretary shall report to the Congress within 12 months after the date of the enactment of this Act with respect to the appropriateness, and impact on States and recipients of medical assistance, of applying standards and methodologies utilized in cash assistance programs to those recipients of medical assistance who do not receive cash assistance, and any recommendations for changes in such requirements.
>
> (4) No provision of law shall repeal or suspend the moratorium imposed by this subsection unless such provision specifically amends or repeals this subsection.

* * * *

45 CFR § 201.3(d) provides:

> Determinations as to whether State plans (including plan amendments and administrative practice under the plans) originally meet or continue to meet, the requirements for approval are based on relevant Federal statutes and regulations. Guidelines are furnished to assist in the interpretation of the regulations.
>
> * * * *

APPENDIX B

The report of the DEFRA Conference Committee, H.R. Rep. 98-861, 98th Cong., 2d Sess. (1984), provides with respect to § 2373(c) of DEFRA:

Present law

Titles V and XIX of the Social Security Act contain certain technical errors.

House bill

Makes technical corrections to titles V and XIX of the Social Security Act.

Senate bill

No provision.

Conference agreement

The conference agreement follows the House bill with a modification as follows. The conference agreement directs the Secretary not to take any compliance, disallowance, penalty or other regulatory action against a State because a State, in determining eligibility for noncash Medicaid recipients, is using an income or resource standard or methodology that is less restrictive than the applicable cash assistance standard or methodology. The Secretary is further directed to report to Congress within 12 months of enactment on the impact of the application of income and resource standards and methodologies under the cash assistance programs to medically needy recipients and other noncash eligibles. The moratorium on Secretarial action is to run from the date of enactment until 18 months after the date on which the Secretary submits her report.

In the Omnibus Budget Reconciliation Act of 1981, P.L. 97-35 (OBRA), States were given certain flexibility in structuring their medically needy programs. They were allowed to limit coverage to cer-

tain categories of medically needy individuals, and to vary the services they offered to the different groups they covered. No change was made or intended with regard to financial eligibility policy. Before OBRA, States could establish income or resource standards or methodologies for their medically needy programs that were, in some cases, less restrictive than those used in the related cash assistance programs.

Effective October 1, 1981, the Secretary issued interim regulations to implement these changes. These regulations made major changes in the pre-OBRA financial eligibility rules, allowing the States to impose more restrictive standards and methodologies than under previous law.

Section 137[(b)](8) of the Tax Equity and Fiscal Responsibility Act, P.L. 97-248 (TEFRA), amended the Medicaid statute to clarify that Congress did not intend to change the policies governing the income and resource standards and methodologies for determining eligibility of the medically needy from those in effect before OBRA. This amendment provided in part that the methodology to be used in determining income and resource eligibility for the medically needy must be the "same methodology" used under the revelant cash assistance program.

The Department has not revised the 1981 interim regulations or otherwise published regulations to implement the TEFRA amendment. However, it is the understanding of the conferees that the Department has implemented this provision in an overly literal fashion, without taking into account the intent of the TEFRA clarification.

For example, the Department is treating certain income and resource rules as "methodology" that must strictly follow SSI or AFDC rules, even though all States with medically needy programs have traditionally been permitted to use less restrictive rules

in certain areas. Thus, the Department has taken the position that aged, blind, and disabled medically needy applicants who enter nursing homes and who have marginally excess resources on the first day of the month can not attain Medicaid eligibility during the month, even after their resources are sufficiently depleted by medical costs, because SSI rules only allow eligibility from the first of the month. The Department has also indicated that it may impose quality control sanctions against the States that are using eligibility procedures that were allowed before OBRA and which make sense in the context of the medically needy program but which happen to be less restrictive than the relevant cash assistance procedures. Similarly, the Department has taken the position that the "single standard" requirement of the TEFRA amendment prohibits States from establishing less restrictive medically needy income levels for single adults and couples because this would result in differences in medically needy income levels among groups of the same family size depending on the relative numbers of adults and children.

The Department's overly restrictive interpretation of section 137[(b)](8) of TEFRA has posed grave administrative problems for the States and threatens to cause great hardship for applicants and beneficiaries. It is also clear to the conferees that the strict application of the cash assistance rules to the medically needy and other noncash groups produces unintended, and in some cases, undesirable, consequences. The conferees have therefore decided to impose a moratorium on the Department's implementation of the TEFRA amendment until the Congress has an opportunity to study and legislate on the matter.

It is the understanding of the conferees that the Department has not yet actually taken a disallowance or quality control penalty against any State. The conferees intend that, during the moratorium, the Secretary not proceed with the imposition of any sanctions,

or otherwise suggest to the States that they must use more restrictive cash assistance standards and methodologies in their medically needy or other noncash recipient programs. States may use less restrictive standards and methodologies in their noncash programs, although they are still foreclosed from being more restrictive than the relevant cash assistance programs. It is the expectation of the conferees that the States will be reasonable in establishing less restrictive variations in the cash assistance methodologies and standards.

APPENDIX C

ROM 2572-D provides:

STATEMENT OF REPLY:

This is in response to a verbal request . . . for clarification of policy regarding the establishment of medically needy income levels. Specifically, the request addressed the issue of setting a medically needy income level for two adults based upon the AFDC payment to a two-person family composed of one adult and one child.

CITATION OF LAW:

Section 1903(f) of the Social Security Act.

REGULATION(S): 42 CFR 435.1007.

REFERENCE TO OTHER RESOURCES:

PIQ 76-15 (MSA); NCSS D-2, July, 1976; Office of Research and Statistics, SSA.

DISCUSSION: This issue involves concerns similar to those inherent in the determination of a medically needy income level for a family of one. PIQ 76-15 (MSA) dated January 22, 1976, addresses this subject and recognizes the existence of the differing maintenance needs of dependent children and medically needy adults. It reads:

> "Per Section 1903(f)(3) of the Social Security Act and 45 CFR 248.4 (b)(4)(ii)(A) in applying the 133⅓ percent limitation to the medically

> needy income levels for single individuals, the 'highest amount which could ordinarily be paid' under the State AFDC program is an amount reasonably related to the State AFDC payment amount for two-person families. Where there is no amount of payment for one person in the AFDC program which is reasonably related to the AFDC payment for two-person families, for example, because the AFDC plan does not provide for payments to single individuals, or such payments are based on reduced need standards applicable only to dependent children and are therefore not related to reasonable maintenance needs of medically needy adults, an amount for one-person families must be established by the State to meet the requirements of this provision."

Additional documentation of the differing maintenance needs of dependent children and adults is offered in the statistics of Federal and State cash payments to these persons:

(1) A comparison of the States' 1976 basic need standards for an AFDC family of two (one adult and one child) and an AFDC family of three (one adult and two children) reveals an average monthly difference of 54.09. Thus, the presence of one additional child in an

AFDC family is recognized as incurring an additional $54.09 to that family's basic needs.

(2) A survey of the 1976 payment levels of twenty-two States offering optional State supplementation for "Basic Needs" to aged persons living independently reveals an average monthly difference of $109.19 between the payment allotted an individual and the payment allotted a couple. Thus, the presence of one additional aged adult in a family is recognized as raising the family's maintenance needs by $109.18.

(3) The Supplemental Security Income financial eligibility standards effective July 1, 1977, authorize a payment of $177.80 to a single person and $266.70 to an eligible couple. Thus, the presence of one additional aged adult is recognized as contributing $88.90 to the couple's maintenance needs.

In order to effectively acknowledge the greater maintenance needs of an adult as opposed to those of a child, the States may set a separate medically needy income level for two adults which would be established between 133⅓ percent of the AFDC payment level for one person and 133⅓ percent of the AFDC payment level for a family of three persons. For example, Montana has established a medically needy income level for two adults at $287 which is within the aforementioned limits of $167 and $334 respectively. This level conforms to the above criteria, satisfies the regulatory requirement of "reasonable relatedness," and recognizes the differing maintenance needs of an adult and a child. The medically needy income level for one adult and one child may not, of course, exceed 133⅓ percent of the AFDC cash payment for a family of two persons.

In view of the greater maintenance needs of an adult as opposed to a child, the regulatory mandate of "rea-

sonably related" income levels contained in [42 CFR 435.1007], and in the interest of comparable treatment of persons with similar needs, the States should have the option of establishing separate medically needy income levels for a two-person family consisting of one adult and one child and for a two-person family composed of two adults.

June 19, 1979

HCFA-ROM-31

APPENDIX D

DEPARTMENT OF HEALTH & HUMAN SERVICES

Region IX
Health Care Financing Administration
Memorandum

Date Mar. 16, 1983

From Associate Regional Administrator
Program Operations

Subject Medically Needy Income Levels for Single Adults and Couples

To Elmer Smith, Director
Office of Eligibility Policy, BERC
Baltimore, Maryland 21207
DPO-222

Refer to

The State of California is under considerable pressure from recipient groups to raise the medically needy income levels for one or two adult person families to higher levels than those for a family consisting of a parent and child. State Assembly Bill #799 revoked California's Special Income Deduction which had previously reduced the spenddown amounts for aged, blind, and disabled medically needy recipients. The HCFA Administrator had disapproved the Special Income Deduction as contrary to federal regulations at 42 CFR 435.1007 which fixes the upper limit on MNIL(s) at 133⅓% of the AFDC payment level for a family of the same size.

Section 2572 of the Regional Office Medicaid Manual (R.O.M. #31 of June 19, 1979 - attached) allowed States to recognize the greater maintenance needs of a single adult and a couple as opposed to a parent and child in setting medically needy income levels. For a MNIL for a family of two adults States could use an amount between 133⅓% of the AFDC payment level for one and for three to recognize the higher mainten-

ance needs of a couple as opposed to a mother and child.

This policy was based on a previous interpretation of the words "reasonably related" stated in federal regulations at 42 CFR 435.1007 and was originally issued in PIQ-77-77 (MSA), June 27, 1977. For a medically needy income level to be considered "reasonably related" to the AFDC payment level for a family of the same size, it was interpreted that the higher needs of adults than children in one and two person families should be accommodated.

T.E.F.R.A., however, has mandated that States use one medically needy income level for all medically needy groups based on family size. Therefore, if a State is to have a different MNIL for a MN adult than it has for a MN child, this practice would constitute the use of different MNIL(s) for different groups of MN recipients and seemingly violate T.E.F.R.A. Furthermore, it appears that the same problem pertains to a State using a lower MNIL for a mother and a child than for an aged, blind, or disabled couple.

Thus, we are asking whether Section 137B of T.E.F.R.A. has invalidated R.O.M. #31 of 6/19/79. If the concept of separate levels for adults and children is still applicable, please advise us whether this practice is optional or mandatory and additionally pertains to families of all sizes dependent upon whether the family group contains one or two adults.

We would appreciate your earliest possible reply on this issue as the State is drafting legislation to raise the medically needy income levels in accordance with R.O.M. #31. We are trying, consequently, to avoid potential compliance problems in this regard. If you have any questions, please call Bruce Campbell of my staff at 556-2191.

/s/ John L. O'Hara, Jr.

Attachment

APPENDIX E

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FQA—63 April 15, 1983

Director
Bureau of Eligibility, Reimbursement
and Coverage

Medically Needy Income Levels for Single Adults and Couples (Your Memorandum Dated March 16, 1983)—
POLICY INFORMATION FOR ALL REGIONS

Regional Administrator
Region IX, San Francisco
Attn: Policy and Technical Assistance Branch
Division of Program Operations

You asked whether, for a specified family size, States may employ more than one medically needy income level (MNIL). That is, may the MNIL vary by family composition depending on the relative numbers of adults and children (as indicated in Regional Office Manual (ROM) section 2572)?

Section 1902 (a)(10)(C) of the Social Security Act (as recently amended by section 137 (b)(8) of TEFRA) provides for a "single standard to be employed in determining income and resource eligibility for all such groups" (of medically needy individuals). Establishing different medically needy levels that would vary by family composition would in effect, result in application of more than a single standard for a group. Thus, we do not believe that States may apply different medically needy income levels for families of the same size but differing in composition of adults and children. We are currently in the process of

clearing regulations which reflect this interpretation through HCFA and the Office of the General Counsel for eventual publication in the *Federal Register*. Upon final clearance, we will take steps to invalidate ROM section 2572.

If you have any questions regarding this memorandum, please call Richard Strauss on (FTS) 934-0629.

/s/ Elmer Smith for
Larry A. Oday

FQA—63 RStrauss:kh 03/30/83
Revised: FQA—63 DCoyne:kh 04/06/83
Revised: MSvolos:mmh 04-11-83
Disc-Kathy II, MEDICALLY NEEDY INC

APPENDIX F

DEPARTMENT OF HEALTH & HUMAN SERVICES

Refer to:

DPO-222

Region IX
Office of the
Regional Administrator
100 Van Ness Avenue
San Francisco, CA 94102

Mrs. Doris Soderberg, Acting Deputy Director
Health Care Policy and Standards Division
Department of Health Services
714 P Street
Sacramento, California 95814

Dear Mrs. Soderberg:

You inquired whether States may employ more than one medically needy income level varying by family composition based on the relative numbers of adults and children in an applicant's family.

Our research has confirmed that Section 1902(a)(10)(c) of the Social Security Act (as recently amended by section 137(b)(8) of TEFRA) provides for a single standard to be employed in determining income and resource eligibility for all such groups of medically needy individuals. Establishing different medically needy income levels that would vary by family composition would, in effect, result in application of more than a single standard for a MN group.

Thus, we do not believe that States may apply different medically needy income levels for families of the same size but differing in the composition of adults and children. HCFA is in the process of finalizing regulations which reflect this interpretation for eventual publication in the *Federal Register*.

The statutory change in TEFRA is considered to be self-implementing and, to the extent that current regulations conflict with the newly revised statute, they no longer have any force and effect.

If you have further questions on this matter, please contact Bruce Campbell of my staff at (415) 556-2191.

Sincerely,

/s/ John L. O'Hara, Jr.
Associate Regional Administrator
Program Operations

cc: Caroline Cabais, Eligibility Branch Chief

APPENDIX G

Section 361 of H.R. 5394, 98th Cong., 2d Sess. (1984), provided:

(a) Section 1903(f)(3) of the Social Security Act (42 U.S.C. 1396b(f)(3)) is amended—

(1) by inserting "(A)" after "(3)", and

(2) by adding at the end the following new sub-paragraph:

"(B) For purposes of paragraph (1)(B), in the case of a family consisting only of two individuals both of whom are adults and at least one of whom is aged, blind, or disabled, the 'highest amount which would ordinarily be paid to a family of the same size' under the State's plan approved under part A of title IV of this Act shall, at the State's option, be the amount determined by the State agency to be the amount of the aid which would ordinarily be payable under such plan to a family which consists of one adult and two children and which is without any income or resources. In the case of a State which has an applicable income limitation under this subsection which is equal to the maximum applicable income limitation permitted consistent with paragraph (1)(B) for families other than those described in the previous sentence, section 1902 (a)(10)(C)(i)(III) shall not prevent the State from establishing under the previous sentence an applicable income limitation for families described in that sentence which is greater than the income limitation applicable to other families".

(b) The amendment made by subsection (a)(2) shall apply to payments to States under section 1903 of the Social Security Act for calendar quarters beginning on or after October 1, 1984.

APPENDIX H

H.R. Rep. 98-442, Pt. 1, 98th Cong., 1st Sess. (1983), provided with respect to § 211 of H.R. 4136, (subsequently § 361 of H.R. 5394):

> Under current law, States have the option of extending Medicaid coverage to the "medically needy." These are low-income adults with dependent children, or aged, blind, or disabled individuals, who have the characteristics necessary to qualify for cash assistance under the Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI) programs, but whose income or resources are too high to permit them to do. In order to receive Medicaid coverage under a State's medically needy program, an individual must "spend down" until his or her medical expenses, when applied against income for the relevant accounting period, reduce that income below the State-established medically needy income level.
>
> The medically needy income level may not be set at a level higher than an amount equal to 133⅓ percent of the highest amount that would ordinarily be paid to an AFDC family of the same size without any income or resources. Prior to the enactment of the Omnibus Budget Reconciliation Act of 1981, P.L. 97-35, Federal guidelines allowed States to set the medically needy income levels for two adults at an amount equal to 133⅓ percent of the AFDC payment for a family of one adult and two children. (HCFA-ROM-31, June 19, 1979). This guideline recognized that a State could find that an adult had greater maintenance needs than a child, and could set its medically needy income level for two adults accordingly.
>
> It is the understanding of the Committee that the Department of Health and Human Services has reversed its policy on this point and taken the position that a medically needy income level for two adults could not, consistent with Federal law, be set at an amount equal to 133⅓ percent of the amount ordinar-

ily paid to an AFDC family of three without income or resources. The Department's new policy appears to be that the medically needy income level for two adults may not be set higher than an amount equal to 133⅓ percent of the amount ordinarily paid to an AFDC family of two without income or resources.

The Committee bill would reinstate the Department's previous policy. States could, at their option, set the medically needy income level for two adults, one of whom is aged, blind, or disabled, at an amount no higher than 133⅓ percent of the highest amount that would ordinarily be paid to a family of one adult and two children without any income or resources under the State's AFDC plan.

The Committee is at a loss to understand why the Department has decided to alter its policy in this regard. The policy is sound; a State could quite logically determine that the maintenance needs of adults differ from those of dependent children. The Committee recognizes that the Omnibus Budget Reconciliation Act of 1981, P.L. 97-35, gave the States more flexibility with respect to the operation of their medically needy programs. The OBRA changes did not, however, extend to income and resource eligibility requirements for the medically needy. This was reaffirmed in the Tax Equity and Fiscal Responsibility Act of 1982, P.L. 97-248, which attempted to reinstate the medically needy income and resource eligibility policies that had been in effect prior to the enactment of OBRA and that the Department had improperly attempted to alter by regulation. The TEFRA provisions, among other things, specified that States are to employ a single standard in determining income and resource eligibility for all groups that the State chooses to cover. The Committee bill makes clear that this single standard requirement does not justify a rejection of the valid 1979 policy with respect to two medically needy adults.

To avoid any further confusion on this point, the Committee provides the folowing hypothetical example of how its amendment would work. Assume that the highest AFDC cash payment is $300 per month in the case of a family of two with no income or resources and $400 per month in the case of a family of three with no income or resources. The State could set its medically needy income level for two adults, one of whom was aged, blind, or disabled, at a level no higher than 133⅓ percent of $400, or $533.32 per month. The State could, of course, set its medically needy income level for two adults at a lower level, say, 133⅓ percent of the $300 payment to an AFDC family of two, or $400 per month. If the State set its medically needy income level for two adults at $400, the income level for AFDC-related medically needy families would have to be the same. If the State chose to set its medically needy income level for two adults above $400 (subject to the $532 per month ceiling), the medically needy income level for a two-person AFDC-related family would have to be set at $400. Medically needy income levels for three-person AFDC-related families would be determined as under previous law. In short, the Committee amendment would relax the single standard requirement only in the limited circumstance in which a State sets its medically needy income level for two adults in excess of 133⅓ percent of the highest cash payment ordinarily made to a family of two under the State's AFDC program.

FEB 18 1987
JOSEPH F. SPANIOL, JR.
CLERK

No. 86-863

In the Supreme Court of the United States

OCTOBER TERM, 1986

OTIS R. BOWEN, SECRETARY OF HEALTH AND HUMAN SERVICES, PETITIONER

v.

KENNETH KIZER, DIRECTOR OF THE CALIFORNIA DEPARTMENT OF HEALTH SERVICES, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

REPLY MEMORANDUM FOR THE PETITIONER

CHARLES FRIED
Solicitor General
Department of Justice
Washington, D.C. 20530
(202) 633-2217

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In the Supreme Court of the United States

OCTOBER TERM, 1986

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REPLY MEMORANDUM FOR THE PETITIONER

The principal holding of the court of appeals is that a statement in an unofficial, unpublished, internal agency manual can rise to the status of a "legislative regulation" that binds the agency, even though the statement is contrary to the plain language of the relevant statute and to the agency's own, duly promulgated, rules. Recognizing the evident weakness of this holding, respondents seek to defend the judgment below mainly by reference to the court's alternative holding concerning the "DEFRA moratorium"—a holding upon which the court of appeals placed only secondary reliance and which occupies but three pages at the end of its decision. As we shall show, respondents' half-hearted efforts to salvage the court's principal holding are quite inadequate. And respondents' discussion of the DEFRA moratorium consists largely of quoting fragments of authorities which, when read in full, disprove the very points respondents proffer.

1. Unable to muster any credible defense for the court of appeals' holding that the regional office manual consti-

tutes a "legislative regulation," respondents abandon that holding altogether (Br. in Opp. 17 n.6). Instead they suggest that the court "could well have rested its judgment upon the ordinary deference which this Court and the courts of appeals have given similar regulatory material" (*id.* at 19). But respondents can point to no instance in which this Court has deferred to an unofficial, incorrect, unpublished and out-of-date internal manual, much less treated such a document as a binding "legislative regulation" as did the court of appeals.[1]

---

[1] Respondents make several errors of characterization. For example, they describe the regional office manual (Br. in Opp. 4) as a document "published by HHS' Health Care Financing Administration." See also Br. in Opp. 21 (referring to the manual as a "published interpretation[]," by which respondents mean that "it was published in the CCH Medicare & Medicaid Guide"). The manual, of course, was not "published" in the Federal Register or any other official source that would be relevant to determining whether it is a "regulation." And its foreword recites that it is "for the use of regional office employees only" (Pet. App. 26a-27a).

Respondents' contention that the manual is entitled to judicial deference as "regulatory material"—a contention that is wholly without merit for the reasons explained in the text—is at odds with their effort to preclude consideration of the manual's foreword on the ground that the manual was "never put in evidence" (Br. in Opp. 20). A party need not "put in evidence" "regulatory material" that is to be given "legislative effect."

Although expressly disclaiming that their argument rests on estoppel theories (Br. in Opp. 25), respondents frequently refer to the State's "reliance" on the regional office manual when passing the legislative amendments to the State Medicaid plan (see *id.* at 4, 21). That supposed reliance is untenable in light of the fact that, as respondents confirm (*id.* at 5), the State was advised of HCFA's contrary view *before* the state legislation was enacted. In any event, the manual provision upon which the state legislature allegedly relied in 1983 had been deleted from the manual in July 1980 (see Pet. 17). Respondents' protestation that the revised manual is not "in evidence" (Br. in Opp. 21-22 n.9) is no more persuasive than their observation that the foreword to the earlier manual is "not in evidence" (Br. in Opp. 20).

Respondents err in suggesting (Br. in Opp. 20) that the decision in *Skidmore* v. *Swift & Co.*, 323 U.S. 134 (1944), a case which antedated the Administrative Procedure Act, "specifically sanctioned deference" to agency materials like the office manual at issue here. Quite the contrary. One need do no more than fill the ellipsis in respondents' truncated quotation from *Swift* (323 U.S. at 140, quoted in Br. in Opp. 20) to see that *Swift* disproves respondents' point. The Court there referred to "rulings, interpretations, and opinions *of the Administrator*" (323 U.S. at 140 (emphasis added)), and both the manual's own terms and the manner in which it was issued make it clear that it was not a ruling or opinion "of the Secretary." In addition, the Court in *Swift* pointed out, as the court below did not, that unofficial regulatory materials are "not controlling upon the courts by reason of their authority" (*ibid.*). Finally, in describing the circumstances in which a nonbinding agency interpretation might nonetheless be entitled to some weight, the decision in *Swift* recited several factors—"the thoroughness evident in its consideration, the validity of its reasoning, [and] its consistency with earlier and later pronouncements" (*ibid.*)—all of which are absent here with respect to the HCFA regional office manual.

Respondents' other efforts to salvage the principal holding of the court below are equally unavailing because they, like the court of appeals, fail to recognize three basic facts. First, the manual provision is inconsistent with the statute and therefore the manual does not, as respondents contend (Br. in Opp. 22), "fill a gap" in the Act. Second, the manual provision is directly contradicted by a duly promulgated regulation, and it is that regulation which must govern. Third, whatever the status of the manual provision, it is clear that *the Secretary* never regarded the manual as a "regulation" or as having any binding force.[2]

---

[2] The Secretary has never delegated the authority to promulgate regulations to the Administrator of HCFA, much less to any subor-

Despite respondents' fanciful suggestions to the contrary, they cannot overcome the basic premise upon which the government's position rests: a family of three is not the "same size" as a family of two.

2. Respondents are on no firmer ground in defending the decision below on the second question presented, the scope of the DEFRA moratorium. As we will show, the legislative history of DEFRA specifically disproves every significant contention that respondents put forward. Preliminarily, however, it will be helpful to explain how respondents' discussion of DEFRA confuses two entirely separate points.

This case involves the 133-1/3% cap on Medicaid benefits under Section 1903(f) of the Social Security Act, 42 U.S.C. 1396b(f). That Section provides that the applicable income limitation for Medicaid purposes is an amount "equivalent to 133-1/3 percent of the highest amount which would ordinarily be paid to a family of the same size" under the State's AFDC program. For example, if a state's maximum AFDC payment were $300 per month for a family of two, the Medicaid income limitation or "cap" would be $400 per month for a family of two. Thus, the state would be in compliance with Section 1903(f) so long as its Medicaid eligibility level for a family of two remained at or below $400.

An altogether different question—not at issue in this case—may arise under Section 1902(a)(10)(C)(i)(III) of the Social Security Act, 42 U.S.C. 1396a(a)(10)(C)(i)(III). That provision, added by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Pub. L. No. 97-248, § 137(b)(8), 96 Stat. 378, requires that a state's Medicaid plan must establish a "single standard" for determining income and resource eligibility. That section was initially

---

dinate HCFA employee. See 42 Fed. Reg. 57352 (1977); 44 Fed. Reg. 31045 (1979).

read by some HHS employees (though not by the Secretary) to require that a family of two consisting of one adult and one child must have the same Medicaid eligibility level as a family of two consisting of two adults. It was this interpretation of the "single standard" provision—*i.e.*, requiring that all families of the same size be treated identically, regardless of how many adults are in the family—that some Congressmen criticized as an "overly literal" reading of TEFRA. See H.R. Conf. Rep. 98-861, 98th Cong., 2d Sess. 1367 (1984). And it was this interpretation of the "single standard" provision that was the subject of the DEFRA moratorium.

A simplified example will show how the 133-1/3% cap of Section 1903(f) operates independently of the "single standard" provision of Section 1902(a)(10)(C)(i)(III). Assume a state, as in the example above, where the highest monthly AFDC benefit ordinarily paid to a family of two is $300. If that state were to establish a Medicaid eligibility level of $350 for a family consisting of one adult and one child, and a separate level of $400 for a family consisting of two adults, a question could thereby be raised under the TEFRA "single standard" provision. But the 133-1/3% cap of Section 1903(f)—*viz.*, $400—would not be exceeded in either event. Conversely, if that same state were to set its Medicaid eligibility level for all families of two (whether consisting of two adults or of one adult and one child) at $450, there would be no question raised under the "single standard" provision. But the state would be in violation of the 133-1/3% cap of Section 1903(f).

During its deliberations preceding the enactment of DEFRA, Congress considered changes to both the "single standard" provision and the 133-1/3% cap. But Congress ultimately decided to amend the statute only with respect to the former. The DEFRA moratorium is expressly directed to "regulatory action against a State * * * by reason of such State's plan [for Medicaid] being deter-

mined to be in violation of section 1902(a)(10)(C)(i)(III)." Pub. L. No. 98-369, § 2373(c)(1), 98 Stat. 1112. The language of the moratorium thus makes plain that it is aimed at the "single standard" provision in Section 1902(a)(10)(C)(i)(III); it makes no mention of the 133-1/3% cap contained in Section 1903(f). On its face, therefore, the DEFRA moratorium does not apply to this case.

The legislative history reinforces the statutory language. It shows that Congress not only limited the moratorium to subjects other than those involved in this case, but also that Congress specifically rejected a proposal which would have accomplished the result that respondents obtained in the court of appeals.

Some members of the House of Representatives did disagree with the Secretary's implementation of Section 1903(f). The House Committee on Energy and Commerce recommended amending Section 1903(f) to provide explicitly that a state could set its Medicaid income level for two adults at an amount equal to the highest AFDC payment ordinarily made to a family of three. H.R. 4136, 98th Cong., 1st Sess. § 211 (1983); see Br. in Opp. App. 17. But that amendment was rejected in conference, and DEFRA contains no such provision. The Conference Report explained (H.R. Conf. Rep. 98-861, *supra*, at 1361):

> Present law
>
> Medically needy income levels for an SSI-related family of two adults with no income or resources, many [sic] be set at a level no higher than 133-1/3 percent of the AFDC standard for a two-person family with no income or resources.
>
> House bill
>
> The House bill permits States to establish medically needy levels for a family of two adults up to 133-1/3 percent of the three-person AFDC standard.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

Respondents attempt to disengage themselves from the consequences of that legislative determination by attributing to Congress motives that appear nowhere in the legislative history. Thus, respondents suggest that Congress rejected the proposed amendment to Section 1903(f) because it was "too limited" and would be redundant in light of the "broader" moratorium (Br. in Opp. 6). But, as we have explained, the moratorium provision is not as broad as respondents propose. To the contrary, it is expressly limited to Section 1902(a)(10)(C)(i)(III), and it cannot rationally be thought to apply by implication to Section 1903(f), since Congress expressly *declined* to amend Section 1903(f) in that way.

Respondents attempt to bridge this gap by pointing to language in the Conference Report concerning "adult couple MNILs" (Br. in Opp. 6). Here again respondents have confused the "single standard" provision with the 133-1/3% cap. The Conference Report states that the moratorium was directed inter alia at the "position that the 'single standard' requirement of the TEFRA amendment prohibits States from establishing less restrictive medically needy income levels for single adults and couples because this would result in differences in medically needy income levels among groups of the same family size depending on the relative numbers of adults and children." H.R. Conf. Rep. 98-861, *supra* at 1367 (quoted in Br. in Opp. 7-8). This statement refers only to the TEFRA "single standard" provision; it does not refer to the 133-1/3% cap. There is no basis for assuming that Congress intended the moratorium to apply to a provision that is not mentioned

in the Conference Report's description of the moratorium's purpose, that is not within the scope of the moratorium's statutory language, and that the Conference Report refused to amend only six pages earlier. And once the clear statutory distinction between Section 1903(f) and Section 1902(a)(10)(C)(i)(III) is recognized, respondents' attempt to draw support from DEFRA's legislative history evaporates.[3]

At bottom, respondents' discussion of the DEFRA moratorium is an effort to inject sufficient confusion into this case to deflect attention from the court of appeals' principal, and profoundly disturbing, holding as to the status of an agency manual as a binding "legislative regulation." That holding does violence to settled principles of administrative law, thwarts specific congressional intent, and substantially undermines federal fiscal control over the Medicaid program. It is a decision that should not be permitted to stand.

For these reasons and those stated in the petition, it is therefore respectfully submitted that the petition for a writ of certiorari should be granted.

CHARLES FRIED
Solicitor General

FEBRUARY 1987

---

[3] A Senate Report (S. Rep. 99-520, 99th Cong. 2d Sess. 21 (1986)) issued in connection with a subsequent effort to clarify the DEFRA moratorium makes it clear that the moratorium was not intended to apply to the Secretary's interpretation of Section 1903(f):

> [T]he moratorium does not eliminate the limits on income and resources of eligible individuals and families under section 1903(f) (including the requirements that the applicable medically needy income level not exceed the amount determined in accordance with standards prescribed by the Secretary to be equivalent to 133 1/3% of the most generous AFDC eligibility standard) * * *.

U.S. GOVERNMENT PRINTING OFFICE: 1986—181-483:40220

(4)

Supreme Court, U.S.
FILED
MAY 19 1987
CLERK

No. 86-863

In the Supreme Court of the United States

OCTOBER TERM, 1986

OTIS R. BOWEN, SECRETARY OF HEALTH AND HUMAN SERVICES, PETITIONER

v.

KENNETH KIZER, DIRECTOR OF THE CALIFORNIA DEPARTMENT OF HEALTH SERVICES, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

JOINT APPENDIX

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Petition for writ of certiorari filed November 26, 1986
Certiorari granted February 23, 1987

7 PP
foldout

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UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

No. 85-7123

STANLEY CUBANSKI, DIRECTOR, DEPARTMENT OF HEALTH SERVICES, STATE OF CALIFORNIA, PETITIONER,

AND

DONALD A. BARRIER AND ALAN & LOLA BIERMAN, ET AL., INTERVENORS-PETITIONERS,

v.

MARGERET HECKLER, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES OF AMERICA, RESPONDENT

RELEVANT DOCKET ENTRIES

DATE	FILINGS-PROCEEDINGS
1985	
MAR. 6	FILED ORIGINAL AND 7 COPIES OF A PETITION FOR REVIEW. cmk $65
MAR. 6	DOCKETED CAUSE & ENTERED APPEARANCES OF COUNSEL. cmk
MAR. 6	NOTIFIED RESPONDENT OF FILING. cmk
MAR. 6	SENT PETITIONER CIVIL APPEALS DOCKETING STATEMENT. cmk
Mar. 25	Filed the motion of Donald A. Barrier, Alan & Lola Bierman, James Jones and Ronald Kwiek, for leave to intervene on behalf of petitioner. 3/20 CIVATT sz
Apr. 1	Filed order (SNEED) The motion by Donald A. Barrier, Alan and Lola Bierman, James Jones, and Ronald Kwiek to intervene in this petition for review is granted. *4/1* dl-

DATE	FILINGS-PROCEEDINGS
Apr. 1	Filed resp's motion for one-day ext. of time to file opposition to motion to intervene. 4/1 (CIVATT) eal
Apr. 1	Recv'd resp's opposition to motion to intervene. 4/1 CIVATT (motion pending) eal
Apr. 8	Recv'd as of Apr. 5, resp's motion for reconsideration of order granting intervention. 4/5 (CIVATT) eal
Apr. 9	Filed intervenors-petrs' motion for stay with appendices. 4/9 (CIVATT) eal
Apr. 9	Recv'd two ltrs from Evelyn R. Frank, dated 4/9 re: motion for stay. 4/9 (CIVATT) eal
Apr. 15	FILED CERT. LIST IN LIEU OF THE RECORD. 4/15 (Orig. & 2 copies) **** ***
Apr. 17	Filed resp's opposition to intervenors' motion for stay. 4/16 (CIVATT) eal
Apr. 17	Filed petr's (State of CA) memorandum of points and authorities in response to intervenor's motion for stay. 4/17 (CIVATT) eal
Apr. 18	Filed intervenor's reply memorandum in support of stay. 4/18 (CIVATT) eal
APR. 19	Filed Order (WRIGHT & HUG) The Secretary's motion for an extension of time to file her opposition to the motion to intervene is granted. The Secretary's opposition is construed as a motion for reconsideration of this court's April 1, 1985 order granting the motion to intervene. Construed as such, the Secretary's motion is denied. The intervenors were permitted to intervene in the agency proceedings and actively participated in those proceedings. There were adequate grounds for our previous order granting the motion to intervene. (4/19) cmk
Apr. 24	Rec'd Petitioner's "CADS". 4/23 (Confatt) dl-

DATE	FILINGS-PROCEEDINGS
APR. 29	Filed Order (WRIGHT, HUG & HALL) Intervenor's motion for stay is denied. Briefing and calendaring of this appeal shall be expedited. The clerk shall calendar this appeal for argument on the first available calendar. Petitioner and intervenors shall file their opening briefs within 14 days of entry of this order. Respondent shall file its answering brief within 14 days of the filing of petitioner's brief. Petitioner and intervenors may file reply briefs within 7 days of the filing of respondent's brief. This schedule shall not be modified except under extraordinary circumstances. Judge HUG would grant the stay. (4/29) cmk
	RELEASED FROM PREBRIEFING CONFERENCE PROGR (PER NPV)
May 2	Filed intervenors-petrs' motion for extension of time. 5/2 (CIVATT) eal
May 10	Filed Order (SNEED) The motion of intervenor-petitioners of May 2, 1985, for an extension of time to June 3, 1985, in which to file the opening brief is Denied. The Opening Brief shall be filed no later than May 20, 1985. 5/10 sz
May 16	Filed Orig. & 15 copies of Petitioners Opening Brief. (14 pgs) & 5 copies on 5/16 (No stmt. or related cases-counsel notified to forward) dl
May 20	Received Orig & 3 copies of intervenor-petitioner's Opening brief, (30 pgs). 5/20 (counsel ntfd to send more copies). sz

DATE	FILINGS-PROCEEDINGS
May 20	FILED AS OF APR. 15, 1985, CERT. TRANSC. OF THE ADMIN. RECORD ON APPEAL IN TWO VOLUMES: VOLS. I & II, PLEADINGS. (CERT. COPIES ONLY) eal
May 28	Rec'd as of May 23, Petitioner-Intervenor's additional copies of the Opening Brief and 5 copies of the excerpt of record. 5/20 dl-
May 28	Filed as of May 20, Org. & 15 copies of Intervenor-Petitioner's Opening Brief. (30 pgs) 5/20 dl
May 29	Rec'd Petitioner's statement of related cases. dl-
Jun. 04	Filed as of Jun. 03, 1985, Orig. & 15 copies of Respondent's Brief. (31 Pgs.) 6/3 dl-
Jun. 10	Filed Orig. & 15 copies of Intervenor's Reply Brief. (17 pgs) 6/10 & 5 copies of Intervenor's Supplemental Excerpts of Record. dl-
Jun. 10	Rec'd Orig. & 15 Copies of Petitioner's Reply Brief. (7 pgs) 6/11 dl- (Late—counsel notified—motion to follow)
June 14	Filed petr's motion to enlarge time to file reply brief. 6/14 CIVATT eal (LATE)
JUNE 25	Filed Order (SNEED) Petitioner's motion of June 14, 1985 for leave to file the reply brief late is granted. The reply brief already received will be filed. (6/25) cmk
JUNE 25	Filed Original and 15 copies of Petitioner's Reply Brief. (7 pgs) 6/11 cmk
June 25	Recv'd as of June 24, ltr from E. Frank, dated 6/21 re: additional citations. 6/21 eal *****
July 1	Recv'd ltr from resp, dated 6/28 re: additional citations. 6/28 (PANEL) eal
July 9	Recv'd ltr from E. Frank, counsel for intervenors, dated 7/1 re: add'l citation. 7/1 (PANEL) eal

DATE	FILINGS-PROCEEDINGS	
AUG 14	ARGUED AND SUBMITTED BEFORE: DUNIWAY, CHOY, FARRIS, CJJ. bp	
1986		
Feb. 7	ORDERED OPINION (DUNIWAY) FILED AND JUDGMENT TO BE FILED AND ENTERED.	
Feb. 7	FILED OPINION—REVERSED.	
Feb. 7	FILED AND ENTERED JUDGMENT.	eal
Feb. 13	Filed intervenor-petr's bill of costs. 2/12	eal
Feb. 18	Recv'd ltr from Evelyn Frank, dated 2/12, re: error in the opinion. 2/12 (PANEL)	eal
Feb. 24	Filed motion & order (Dep Clk) granting resp an ext of time to & including Mar. 21, 1986 to file the petition for rehearing. 2/24	eal
Feb. 25	Filed intervenor-petrs' association of counsel, adding Stephen Berzon & Michael Rubin as special counsel with respect to intervenors' claim for attys' fees. 2/24	eal
Mar. 6	Filed Order (DUNIWAY, CHOY & FARRIS) It is hereby ordered that the next to the last line on pg 5 of the slip opinion in this case is amended to read as follows: (See case file for complete text).	eal
Mar. 10	Filed intervenor-petrs' notice of motion & motion for award of attys' fees and costs. 3/10 (CIVATT)	eal
Mar. 21	Filed Orig & 33 copies of respondent's Petition for Rehearing and Suggestion for Rehearing en banc. 3/20 (PANEL & ALL ACTIVE JUDGES)	sz
June 30	Received Orig & 33 copies of additional citations from respondent. 6/27 (PANEL & ALL ACTIVE JUDGES)	sz

DATE	FILINGS-PROCEEDINGS
July 14	Filed order (DUNIWAY, CHOY & FARRIS) The Petition for rehearing in banc is rejected, and the petition for rehearing is denied. *7/14* dl-
Jul 21	Filed as of 7/17, pet-intervenors' application for a 14 day extension of time to file brief & declarations in support of attys. fees application. 7/17 (Panel) ogm
Jul 21	Filed as of 7/18/86, Judge Kozinski's dissent from rejection of suggestion for rehearing en banc. ogm
1986	
JUL 23	MANDATE ISSUED (COSTS TAXED)
Aug 7	Filed as of 8/5, pet-intervenors' application for further extension of time to file brief & declarations in support of attys. fees application. (Panel) 8/4 ogm
Aug 11	Filed as of 8/8, Supplemental declaration of Michael Rubin in support of Intvs' request for extension of time. (Panel) 8/8 ogm

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

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November 30, 1984

Ralph M. Johnson, Esq.
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Re: California State Plan Amendment No. 83-14—
Docket No. 84-6

Dear Mr. Johnson:

A copy of my recommended decision is enclosed. By copy of this letter, I am transmitting copies of the decision to all parties, and advising them of their right to file exceptions. In accordance with 45 CFR 213.32(b), parties may file exceptions to the hearing officer's findings and recommended decision within 20 days of receipt of this letter. Any such exceptions should be submitted to the attention of Irwin Cohen, Attorney Adviser, Room 669 East High Rise, 6325 Security Boulevard, Baltimore, Maryland 21207.

Sincerely yours,

/s/ LAWRENCE J. AGELOFF

Lawrence J. Ageloff
Director
Hearing Staff

Enclosure

cc:
Evelyn R. Frank, Esq.
Brenda Kohn, Esq.

FQA-61:AJAgeloff:bw 11/30/84

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Docket No. 84-6

IN THE MATTER OF:
THE DISAPPROVAL OF CALIFORNIA STATE PLAN AMENDMENT 83-14

RECOMMENDED DECISION

Facts

California's State Plan Amendment 83-14, which was received by the Health Care Financing Administration (HCFA) on September 27, 1983 and denied on December 19, 1983, proposed to establish a medically needy income level (MNIL) for a family of two adults at 133⅓ percent of the State's AFDC payment level for a family of three. The proposed amendment was denied because it violated sections 1903(f)(1)(B), 1902(a)(4) and 1902(a)(19) of the Social Security Act (SSA) and Federal regulations at 42 CFR 435.1007.[1] The State requested reconsideration timely pursuant to section 1116(a)(2) of the SSA, 45 CFR 201.4 and 45 CFR Part 213. Following publication of the notice of hearing in the *Federal Register,*[2] the Legal Aid Society of Alameda County filed a Petition to Intervene which was granted by the Hearing Officer. Pursuant to a mutually agreed upon continuance, the hearing was held on July 2, 1984 in San Francisco, California.[3] All of the parties agreed that the hearing presented a question of law and

[1] See Attachment 1 hereto for a description of the citations given above

[2] 49 FR 10165, March 19, 1984

[3] The hearing was originally scheduled to be held on May 8, 1984.

not of fact. The hearing record was closed on November 10, 1984, 10 days after the date the last closing brief was received.

Issue

Whether California's proposed amendment to establish a MNIL for a family of two adults at 133⅓ percent of the State's AFDC payment level for a family of three is in violation of the law or regulations?

Applicable Law and Regulations

Section 1116(a)(2) of the SSA
Section 1903(f)(1)(B) of the SSA
Section 1902(a)(4) of the SSA
Section 1902(a)(19) of the SSA
42 CFR 435.1007
Regional Office Manual 2572
Section 2373(c) of the Deficit Reduction Act of 1984

Discussion

California's sole contention is that State Plan Amendment 83-14 is authorized by Regional Office Manual (ROM) 2572D[4] and should be approved. In addition to ROM 2572D, the Intervenor attacks the disapproval of 83-14 on several other grounds. The Intervenor argues that the Deficit Reduction Act (DRA) prohibits the disallowance of 83-14; the proposed amendment is consistent with Section 1903(f) of the SSA; if the proposed amendment is disallowed, the State should be given an opportunity to submit a new plan before fiscal sanctions are imposed; and due process precludes the Administrator from making a decision in this case. For the following

[4] See Attachment 2 hereto for a copy of ROM 2572D.

reasons, the arguments advanced by the State and Intervenor are rejected and it is recommended that the initial disapproval be affirmed.

ROM 2572 and the Deficit Reduction Act of 1984

ROM 2572 gave States the option of establishing a separate MNIL for two adults which was between 133⅓ percent of the AFDC payment level for one person and 133⅓ percent of the AFDC payment level for a family of three persons. The exercise of this option would result in a two adult family receiving a higher MNIL than a 2 person AFDC family. By setting the MNIL for two adults at the upper limit of 133⅓ percent of the AFDC payment level for a family of three persons, California's proposed amendment would be consistent with ROM 2572. The ROM has never been used by the San Francisco Regional Office, which was unaware of the ROM's existence until it was brought to its attention by the Intervenor's attorney (Tr. pp. 51, 52).

The State and Intervenor base their ROM 2572 arguments on several grounds. HCFA, they contend, is bound by its own regulations and procedures. However, ROM 2572 is not a regulation and unlike the procedure in *Morton* v. *Raiz*, 415 U.S. 199, 945 S. Ct. 1055 (1973), the procedure relied on by HCFA to limit MNIL payments to two adult families is supported by law (section 1903(f)(1)(B)(i)), regulation (42 CFR 405.1007), and congressional intent.

The ROM contains program instructions for regional offices. It serves as a supplement to other health insurance manuals and is intended for internal regional office use, i.e., for the use of regional office employees only. The foreward to the ROM instructs regional office employees not to cite the ROM to others, and the testimony of Mr. Campbell, who was the California Eligibility Specialist for the Regional Office from 1979 through 1983, that he was

not aware of the existence of ROM 2572 until it was brought to his attention by the Intervenor's attorney shows that the regional office's conduct did not cause California to propose 83-14. Nor was any evidence introduced which showed that California knew of or relied on ROM 2572 when it prepared its proposed plan amendment. ROM 2572 was not published in the *Federal Register* or the Code of Federal Regulations. The ROM is restricted to Central Office employees, and if anything, has less, but certainly no more importance than the SSA Claims Manual, a multi volume handbook containing internal instructions used by thousands of SSA employees for taking, developing and adjudicating applications for SSA benefits. Like the Claims Manual, the ROM is not a regulation, has no legal force, and does not bind HCFA. *Schweiker* v. *Hansen*, 450 U.S. 783, 101 S. Ct. 1468(1981). By its own terms, ROM 2572 is an internal interpretation of 42 CFR 435.1007[5] and section 1903(f) of the SSA. As such, it falls within the "interpretive rules" exception to the Administrative Procedures Act[6] (APA) and need not be published in the *Federal Register*. For the same reason, the revision of an internal interpretative rule need not be published with notice and comment in the *Federal Register*, especially when, as here, the internal interpretative instruction was never used in the region and was not relied upon by the State in fashioning its Amendment.

The Intervenor also posits that section 552(a)(1)(D) of the Freedom of Information Act (FOIA)[7] requires pub-

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[5] This was previously 45 CFR 248.4(b)(4)(ii)(A)

[6] Section 552(a)(2) of the APA exempts from the publication requirement certain "statements of policy and interpretations which have been adopted by the agency," and administrative staff manuals.

[7] § 552(a)(1)(D) of the FOIA requires that each agency "shall . . . publish in the *Federal Register* . . . substantive rules of general applicability adopted as authorized by law, and statements of general

lication of the repeal of ROM 2572 in the *Federal Register* before repeal can take effect. However, section 552(a)(1)(D) is not controlling. As stated above, ROM 2572 was an internal regional office instruction, which was not published in the *Federal Register* since it met the exemption in section 552(a)(2) of the APA. In addition, ROM 2572 was HCFA's erronious [sic] attempt to explain an existing law and regulation and had no significant impact upon any segment of the public since it was not implemented in Region IX nor did the State of California rely on it in preparing and submitting its proposed amendment. Consequently, ROM 2572 is not a "substantive rule of general applicability" *Anderson* v. *Butz,* 550 F.2d. 459(1977), *Lewis* v. *Weinberger,* 415 F. Supp. 652 (D.N.M. 1976).

The FOIA section governing HCFA's repeal of ROM 2572 is 552(a)(2)(B) which states that each agency "shall make available for public inspection and copying—

(B) Those statements of policy and interpretations which have been adopted by the agency and are not published in the *Federal Register*;"

Section 552(a)(2)(B) is the category of the FOIA in which ROM 2572 falls—a category that does not require publication. Under FOIA HCFA was required to make ROM 2572 available for public inspection and copying and was not precluded from changing its policy interpretation absent publication.

Although I may sympathize with the intended result of the proposed Amendment, Congress specifically rejected ROM 2572's interpretation of section 1903(f) of the SSA. In its deliberation of DRA, the House bill permitted States to establish MNIL for a family of two adults up to 133⅓ percent of the three person AFDC standard. The

---

policy or interpretations of general applicability formulated and adopted by the agency."

Senate made no such provision and the Conference agreement did not include the House provision. Conf. Rep. on H. Rep. 98-861, 98th Cong. 2nd Sess (1984), p. 1361. Thus, there is no support for the argument that ROM 2572 correctly interpreted § 1903(f). Similarly, there is no support for the claim that DRA "specifically prohibited the Secretary from taking any regulatory action against a State based on its use of an adult couple MNIL." (Int. Br. at p. 8) Section 2373(c) of DRA, which Intervenor relies on, is limited to violations of section 1902(a)(10)(C)(i)(III) of the Act and does not touch upon violations of section 1903(f).

The legislative history of DRA indicates that HCFA's refusal to implement ROM 2572 is correct, and supports the disallowance of State Plan Amendment 83-14.

Sanctions and Due Process

There are two other arguments advanced by the Intervenor which should be discussed. The Intervenor states that if the initial disallowance is affirmed, the State should be given an opportunity to submit a new plan before fiscal sanctions are imposed. However, this issue is not before the Hearing Officer. This is a hearing under 45 CFR 201.4[8] and is limited to a reconsideration of the initial determination disallowing California's State Plan Amendment 83-14. The determination under review does not involve the withholding of Federal payments.

The final argument involves a due process claim. It states that the Administrator may not, consistent with due process, participate in making a decision in this proceeding. It should be noted that section 1116(a)(2) of the SSA specifically states that [t]he Secretary shall affirm, modify or reverse his original determination . . . ."

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[8] A State is entitled to a hearing in accordance with 45 CFR 201.6 when Federal payments are withheld.

Thus, the Secretary, through the Administrator to whom she has delegated the authority to hold these hearings, is following a Congressional directive in holding these hearings. Nor can it be persuasively argued that Congress was not aware that the Secretary was also the original decision maker when it considered and passed section 1116(a)(2) of the Act. In any event, although I do not find the due process argument persuasive, it is not within my jurisdiction since constitutional questions can only be answered by the Courts.

Findings and Conclusions

1. ROM 2572 is an internal RO instruction. It is not a regulation, has no legal force and does not bind HCFA.

2. The State of California did not rely on ROM 2572 in preparing its State Plan Amendment 83-14.

3. ROM 2572 meets the "interpretive rule" exception to the APA and was not required to be published in the *Federal Register*.

4. ROM 2572 is covered by section 552(a)(2)(B) of the FOIA and was not required to be published in the *Federal Register*.

5. Congress specifically rejected ROM 2572's interpretation of section 1903(f) of the Act.

6. Section 2373(c) of DRA is limited to violations of section 1902(a)(10)(c)(i)(III) of the Act.

7. DRA supports HCFA's refusal to implement ROM 2572.

8. This proceeding does not involve the imposition of financial sanctions and thus the question as to whether the State should be given an opportunity to submit a new plan before such a penalty is imposed is not before me.

9. Under section 1116(a)(2) of the SSA, the Administrator is authorized to make a hearing decision on State Plan Amendments.

10. California's State Plan Amendment 83-14 was not condusive to the proper and efficient operation of the plan required by section 1902(a)(4) since it was in violation of section 1903(f) of the Act.

11. California's State Plan Amendment 83-14 violates section 1902(a)(19) of the Act since, rather than providing safeguards to assure proper eligibility determinations, it proposed to establish eligibility criteria for an adult family of two which violate section 1903(f).

Decision

I recommend that the disapproval of California's State Plan Amendment 83-14 be affirmed.

November 30, 1984
Date

/s/ LAWRENCE J. AGELOFF
Lawrence J. Ageloff

Attachment 1

Section 1903(f)(1)(B) states:

> (B)(i) Except as provided in clause (ii) of this subparagraph, the applicable income limitation with respect to any family is the amount determined, in accordance with standards prescribed by the Secretary, to be equivalent to 133⅓ percent of the highest amount which would ordinarily be paid to a family of the same size without any income or resources, in the form of money payments, under the plan of the State approved under Part A of title IV of this Act.

Section 1902(a)(4) states in pertinent part: A State plan for medical assistance must provide . . . such methods of administration . . . as are found by the Secretary to be necessary for the proper and efficient administration of the plan. . . ."

Section 1902(a)(19) states:

> "A State plan for medical assistance must provide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients."

42 CFR 435.1007 states in pertinent part:

> "(a) FFP is available in expenditures for services provided to medically needy recipients whose annual income after deductions specified in § 436.831(a) and (c) and § 436.832 does not exceed the following amounts, rounded to the next higher multiple of $100:
>
> (1) For couples and families of two or more, 133⅓ percent of the highest money payment that would ordinarily be made under the State's AFDC plan to a family of the same size without income and resources.

If the States's AFDC plan specifies a maximum family size beyond which there is no increase in benefits, the medically needy income levels for families whose size exceeds that maximum will be determined by adding an amount for each family member over the maximum size. These amounts must be reasonably related to the amounts by which the State's AFDC plan increases benefits for additional family members in families below the maximum size.

Attachment 2

2572. LIMITATIONS ON FFP

D. *Medically Needy: Determination of a Medically Needy Income Level for Two Adults.*—Reissuance of PIQ-77-77(MSA), June 27, 1977.

STATEMENT OF REPLY: This is in response to a verbal request from Barbara Costa of your office for clarification of policy regarding the establishment of medically needy income levels. Specifically, the request addressed the issue of setting a medically needy income level for two adults based upon the AFDC payment to a two-person family composed of one adult and one child.

CITATION OF LAW: Section 1903(f) of the Social Security Act.

REGULATION(S): 45 CFR 248.4(b)(4)(ii)(A) [42 CFR 425.1007]

REFERENCE TO OTHER RESOURCES: PIQ 76-15(MSA); NCSS D-2, July, 1976; Office of Research and Statistics, SSA.

DISCUSSION: This issue involves concerns similar to those inherent in the determination of a medically needy income level for a family of one.

PIQ 76-15(MSA) dated January 22, 1976, addresses this subject and recognizes the existence of the differing maintenance needs of dependent children and medically needy adults. It reads:

> "Per Section 1903(f)(3) of the Social Security Act and 45 CFR 248.4(b)(4)(ii)(A) in applying the 133⅓ percent limitation to the medically needy income levels for single individuals, the "highest amount which could ordinarily be paid" under the State AFDC program is an amount reasonably related to the State AFDC payment amount for two-person families. Where there is no amount of payment for one person in the AFDC program which is reasonably related to the AFDC payment for two-person families, for example, because the AFDC plan does not provide for payments to single individuals, or such payments are based on reduced need standards applicable only

only to dependent children and are therefore not related to reasonable maintenance needs of medically needy adults, an amount for one-person families must be established by the State to meet the requirements of this provision."

Additional documentation of the differing maintenance needs of dependent children and adults is offered in the statistics of Federal and State cash payments to these persons:

(1) A comparison of the States' 1976 basic need standards for an AFDC family of two (one adult and one child) and an AFDC family of three (one adult and two children) reveals an average monthly difference of $54.09. Thus, the presence of one additional child in an AFDC family is recognized as incurring an additional $54.09 to that family's basic needs.

(2) A survey of the 1976 payment levels of twenty-two States offering optional State supplementation for "Basic Needs" to aged persons living independently reveals an average monthly difference of $109.19 between the payment allotted an individual and the payment allotted a couple. Thus, the presence of one additional aged adult in a family is recognized as raising the family's maintenance needs by $109.18.

(3) The Supplemental Security Income financial eligibility standards effective July 1, 1977, authorize a payment of $177.80 to a single person and $266.70 to an eligible couple. Thus, the presence of one additional aged adult is recognized as contributing $88.90 to the couple's maintenance needs.

In order to effectively acknowledge the greater maintenance needs of an adult as opposed to those of a child, the States may set a separate medically needy income level for two adults which would be established between 133⅓ percent of the AFDC payment level for one person and 133⅓ percent of the AFDC payment level for a family of three persons. For example, Montana has established a medically needy income level for two adults at $287 which is within the aforementioned limits of $167 and $334 respectively. This level conforms to the above criteria, satisfies the regulatory requirement of "reasonable relatedness," and recognizes the differing maintenance needs of an adult and a child. The medically needy income level for one adult and one child may not, of course, exceed 133⅓ percent of the AFDC cash payment for a family of two persons.

In view of the greater maintenance needs of an adult as opposed to a child, the regulatory mandate of "reasonably related" income levels contained in 45 CFR 248.4(b)(4)(ii)(A), and in the interest of comparable treatment of persons with similar needs, the States should have the option of establishing separate medically needy income levels for a two-person family consisting of one adult and one child and for a two-person family composed of two adults.

June 19, 1979

HCFA-ROM-31

[JOINT EXHIBIT 1]

...OF HEALTH AND ...MAN SERVICES
...FINANCING ADMINISTRATION

Submit 6 Copies.

...SMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
...OR: HEALTH CARE FINANCING ADMINISTRATION

TRANSMITTAL NUMBER	STATE
83-12	California

PROGRAM IDENTIFICATION: Medicaid

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

PROPOSED EFFECTIVE DATE: July 1, 1983

039

TYPE OF PLAN MATERIAL (Check One)

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☑ AMENDMENT

COMPLETE NEXT 4 BLOCKS IF THIS IS AN AMENDMENT (Separate transmittal for each amendment)

FEDERAL REGULATION CITATION: 42 CFR 435, 436 & 440

NUMBER OF THE PLAN SECTION OR ATTACHMENT	NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT
Attachment 2.6-A (page 7) Supplement 1 to Attachment 2.6-A	Attachment 2.6-A (page 7) Supplement 1 to Attachment 2.6-A

SUBJECT OF AMENDMENT

Eligibility Conditions & Requirements

GOVERNOR'S REVIEW (Check One)

☑ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

SIGNATURE OF STATE AGENCY OFFICIAL

TYPED NAME: Peter Rank

TITLE: Director

DATE: September 20, 1983

RETURN TO:
Department of Health Services
Office of Regulations
714 P Street, Room 1601
Sacramento, CA 95814

FOR REGIONAL OFFICE USE ONLY

DATE RECEIVED	DATE APPROVED
09-27-83	

PLAN APPROVED – ONE COPY ATTACHED

EFFECTIVE DATE OF APPROVED MATERIAL

SIGNATURE OF REGIONAL OFFICIAL

TYPED NAME: John L. O'Hara, Jr.

TITLE: Associate Regional Administra...

REMARKS:

Joint Exhibit 1
Page 1 of 3

[JOINT EXHIBIT 1]

22

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State California

ELIGIBILITY CONDITIONS AND REQUIREMENTS

040

23 [JOINT EXHIBIT 1 – Continued]

Citation	Condition or Requirement
	___ The disregards of the State supplementary payment program, as follows:
	___ The disregards of the SSI program, except for the following restrictions.
	___ e. For the medically needy, the agency applies disregards, as specified in Supplement 3 to Attachment 2.6A, in addition to items 1a-d.
435.812	2. Medically Needy Income Levels
	X a. All groups
	One MNIL is used for all covered medically needy groups as follows:
	___ (1) MNIL equal to the highest income or payment standard used in the cash assistance programs (or optional State supplement) related to the covered medically needy groups.
	X (2) MNIL equal to highest level permitted under 42 CFR 435.1007, except for 2 adults, MNIL equal to 133 1/3% of AFDC payment level for 3 persons.

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TN # _____
Supersedes Approval Date Effective Date

Revision: FA-AT-81-37

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

SUPPLEMENT 1 TO
Attachment 2.6-A

State California

INCOME LEVELS - MEDICALLY NEEDY

041

_x_ Applicable to all groups ___ Applicable to:

Based on 133 1/3 percent of the AFDC payment levels.

Family Size	Net income level protected for maintenance ___ urban only ___ urban & rural	Amount by which Column (2) exceeds limits specified in 42 CFR 435.1007 1/	Net income level for persons living in rural areas	Amount by which Column (4) exceeds limits specified in 42 CFR 435.1007 1/
(1)	(2)	(3)	(4)	(5)
1	459	0		
2	567	0		
2 Adults	709	142		
3	709	0		
4	834	0		
5	959	0		
6	1075	0		
7	1175	0		
8	1284	0		
9	1384	0		
10	1492	0		
Additional Person Add:				

1/ The agency has methods for excluding from its claim for FFP payments made on behalf of individuals whose income exceeds these limits.

Joint Exhibit 1
Page 3 of 3

TN #
Supersedes
TN #

Approval Date Effective Date

[JOINT EXHIBIT 2]

DEC 19 1983

Mr. Peter Rank
Director
Department of Health Services
714/744 P Street, Room 1601
Sacramento, California 95814

Dear Mr. Rank:

We have reviewed California's Medicaid State Plan Amendment No. 83-14 and are unable to approve the proposed changes to revise the medically needy income level (MNIL) for a family of two adults.

Section 1903(f)(1)(B) of the Social Security Act and implementing Federal regulations at 42 CFR 435.1007 provide that Federal Financial Participation (FFP) in expenditures for services is only available where the income (after deduction of incurred medical expenses) for a two adult family does not exceed 133⅓ percent of the highest amount ordinarily paid to a two person family (without income or resources) under the State's Aid to Families with Dependent Children (AFDC) program. State Plan Amendment No. 83-14 proposes to establish a MNIL for two adults at 133⅓ percent of the State's AFDC payment level for a family of three.

Although the 133⅓ limit under section 1903(f)(1)(B) of the Act is not strictly speaking a State plan requirement, the statute is clear that FFP is not available for medical assistance to persons whose income exceeds that limit. By

setting the MNIL for a family of two adults at 133⅓ percent of the AFDC level for a family of three, California could provide medical assistance to individuals with income in excess of the limitation. In light of that fact, approval of the proposed State plan amendment would not be consistent with the "proper and efficient operation of the plan" and would thus violate section 1902(a)(4) of the Act. Further, such approval would not be "consistent with simplicity of administration" as required under section 1902(a)(19) of the Act.

Based on the above and after consultation with the Secretary as required by 45 CFR 201.3, I am hereby disapproving the subject plan amendment because it is in violation of existing Federal law and regulations. If you are dissatisfied with this determination you may petition for reconsideration of the issue in accordance with the procedure set forth in 45 CFR 201.4.

If you wish to discuss the implications of this disapproval further, please contact Mr. John L. O'Hara, Jr., Associate Regional Administrator, 100 Van Ness Avenue, 14th Floor, San Francisco, California 94102.

Sincerely yours,

/s/ CAROLYNE K. DAVIS, PH.D.
Carolyne K. Davis, Ph.D.

[JOINT EXHIBIT 3]

Federal Register/Vol. 49, No. 54/Monday, March 19, 1984/Notices

Health Care Financing Administration

Medicaid Program; Hearing;
Reconsideration of Disapproval of a
California State Plan Amendment

Agency: Health Care Financing Administration (HCFA), HHS.
Action: Notice of hearing.

SUMMARY: This notice announces an administrative hearing May 8, 1984, in San Francisco, California, to on reconsider our decision to disapprove California State Plan Amendment 83-14.

Closing date: Requests to participate in the hearing as a party must be received by April 3, 1894.

FOR FURTHER INFORMATION CONTACT: Docket Clerk, Hearings Staff, Bureau of Eligibility, Reimbursement and Coverage, 365 East High Rise, 6325 Security Boulevard, Baltimore, Maryland 21207, Telephone: (301) 594-8261.

SUPPLEMENTARY INFORMATION: This notice announces an administrative hearing to reconsider our decision to disapprove a California State Plan Amendment.

Section 1116 of the Social Security Act and 45 CFR Parts 201 and 213 establish Department procedures that provide an administrative hearing for reconsideration of a disapproval of a State plan or plan amendment. HCFA is required to publish a copy of the notice to a State Medicaid Agency that informs the agency of the time and place of

the hearing and the issues to be considered. (If we subsequently notify the agency of additional issues which will be considered at the hearing, we will also publish that notice.)

Any individual or group that wants to participate in the hearing as a party must petition the Hearing Officer within 15 days after publication of this notice, in accordance with the requirements contained in 45 CFR 213.15(b)(2). Any interested person or organization that wants to participate as amicus curiae must petition the Hearing Officer before the hearing begins, in accordance with the requirements contained in 45 CFR 213.15(c)(1).

If the hearing is later rescheduled, the Hearing Officer will notify all participants.

The issue in this matter is whether California's proposal to revise the Medically Needy Income Level (MNIL) for determing Medicaid eligibility for a family of two adults violates section 1903(f)(1)(B), 1902(a)(4) and 1902(a)(19) of the Social Security Act and Federal regulations at 42 CFR 435.1007.

Section 1903(f)(1)(B) of the Social Security Act and implementing Federal regulations at 42 CFR 435.1007 provide that Federal Financial Participation (FFP) in expenditures for services is only available where the income (after deduction of incurred medical expenses) for a two adult family does not exceed 133⅓ percent of the highest amount ordinarily paid to a two person family (without income or resources) under the State's Aid to Families with Dependent Children (AFDC) program. California State Plan Amendment No. 83-14 proposed to establish a MNIL for two adults at 133⅓ percent of the State's AFDC payment level for a family of three.

Although the 133⅓ limit under section 1903(f)(1)(B) of the act is not strictly speaking a State plan requirement, the statute provides that FFP is not available for medical assistance to persons whose income exceeds that limit.

By setting the MNIL for a family of two adults at 133⅓ percent of the AFDC level for a family of three, California could provide medical assistance to individuals with income in excess of the limitation. Therefore, HCFA determined that the proposed State plan amendment would not be consistent with the "proper and efficient operation of the plan" and would thus violate section 1902(a)(4) of the Act. In addition HCFA has determined California's proposed plan violates section 1902(a)(19) of the Act which requires a plan to be "consistent with simplicity of administration."

The notice to California announcing an administrative hearing to reconsider our disapproval of its State plan amendment reads as follows:

Mr. Peter Rank,
Director, Department of Health Services, 714/744 P Street, Room 1601, Sacramento, Calif.

Dear Mr. Rank: This is to advise you that your request for reconsideration of the decision to disapprove California State Plan Amendment 83-14 was received on February 16, 1984. You have requested a reconsideration of whether this plan amendment, which would revise the Medically Needy Income Level for determining Medicaid eligibility for a family of two adults, conforms to the requirements for approval under the Social Security Act and pertinent Federal requirements.

I am scheduling a hearing on your request to be held on May 8, 1984, at 10 a.m., in Room 26A, 100 Van Ness Avenue, San Francisco, California. If this date is not acceptable, we would be glad to set another date that is mutually agreeable to the parties.

I am designating Mr. Lawrence Ageloff as the presiding official. If these arrangements present any problems, please contact the Docket Clerk. In order to facilitate any communication which may be necessary between the parties to the hearing, please notify the Docket Clerk of the names of the individuals who will represent the State at the hearing. The Docket Clerk can be reached at (301) 594-8261.

Sincerely yours,

Carolyne K. Davis, Ph.D.

(Section 1116 of the Social Security Act (42 U.S.C. 1316))

(Catalog of Federal Domestic Assistance Program No. 13.714, Medical Assistance Program)

Dated: March 13, 1984.

Carolyne K. Davis,

Administrator, Health Care Financing Administration.

[FR Doc. 84-7284 Filed 3-16-84; 8:45 am]

BILLING CODE 4120-03-M

[JOINT EXHIBIT 4]

DEPARTMENT OF HEALTH SERVICES
714/744 P Street
Sacramento, CA 95814 Feb 16 1984

Mr. John L. O'Hara, Jr.
Associate Regional Administrator
Health Care Financing Administration
100 Van Ness Avenue, 14th Floor
San Francisco, CA 94102

Dear Mr. O'Hara:

This is to request reconsideration of HCFA's disapproval of California's State Plan Amendment (SPA) No. 83-14 proposing to increase the maintenance need income levels (MNIL) applicable to its medically needy (MN) families, and to provide MNIL for families of two adults separate from the MNIL for other families of two.

Ms. Davis' stated reasons for this disapproval were: (1) The proposal to establish a separate MNIL for families of two adults at 133⅓ of the State's Aid to Families with Dependent Children (AFDC) payment rate for a family of three exceeded the limits for federal financial participation (FFP) described in 42 CFR 435.1007; (2) allowance of this higher MNIL for families of two adults would "not be consistent with the 'proper and efficient operation of the plan' and would thus violate Section 1902(a)(4) of the Act"; and, (3) "such approval would not be 'consistent with simplicity of administration' as required under Section 1902(a)(19) of the Act".

I am unable to ascertain the precise reasons for disapproval. HHS/HCFA has officially recognized in HCFA Regional Office Manual, Part 6, Medicaid Guidelines, Transmittal No. 30 (June 30, 1979), Section 2572-D. "Medically Needy: Determination of a Medically Needy Income Level for Two Adults" that, based on the existence

of the differing maintenance needs of dependent children and medically needy adults, a higher maintenance need for families composed of two adults is legally appropriate under the Social Security Act and HHS/HCFA regulations. The guideline states that it is appropriate to establish an MNIL for two adults between 133⅓ percent of the AFDC payment level for one person and 133⅓ percent of the AFDC payment level for a family of three persons. The justification for this guideline is the regulatory mandate of "reasonably related" income levels in 42 CFR 435.1007. This particular regulatory language has not been amended to date and does not appear to be affected by subsequent legislation, including the Tax Equity and Fiscal Responsibility Act of 1982.

Accordingly, because this guideline would appear to remain valid, and because the Department's MNIL for two adults does not exceed the guideline limits, disapproval of the State Plan Amendment on the basis that it exceeds FFP limits in 42 CFR 435.1007 appears to be incorrect.

Additionally, because, as is noted in the disapproval letter, 42 CFR 435.1007 is not a State Plan requirement, I fail to see how this can be the basis of a disapproval of the SPA by HHA/HCFA under 45 CFR 201.3. This regulation, and the statute being implemented, Section 1116 of the Social Security Act (42 U.S.C., Section 1316), relate only to the Administrator's authority to approve or disapprove the State Plan and SPAs.

Finally, the Administrator's letter states that approval of the State Plan Amendment would not be consistent with the "proper and efficient operation of the plan" (Section 1902 (a)(4) of the Act) or "consistent with simplicity of administration" (Section 1902 (a)(19) of the Act). The basis for this contention is not clear. This conclusion appears to be based on the assumption that the two adult

MNIL exceeds maximum FFP limits. This conclusion, as was pointed out above, is inconsistent with HHS/HCFA policy interpretations.

In conclusion, the MNIL for two adults does not exceed the maximum FFP limit set by HHS/HCFA. As such, and because there has been no disruption in the administration of the Medi-Cal program as a result of this change, I believe the disapproval of SPA No. 83-14 is erroneous and I request reconsideration of this decision in accordance with 45 CFR 201.4.

If you have any questions regarding the above, please contact Caroline Cabias, Chief, Medi-Cal Eligibility Branch at (916) 445-1912.

Sincerely,

Original Signed By
Pat Rauscher

Peter Rank
Director

cc: Jim Scott
Office of Assistant Secretary for
Legislation
Department of Health and Human
Services
200 Independence Avenue,
Southwest
Washington, DC 20201

[JOINT EXHIBIT 5]

The Administrator
Washington, D.C. 20201

MAR 13 1984

Mr. Peter Rank
Director
Department of Health Services
714/744 P Street, Room 1601
Sacramento, California 95814

Dear Mr. Rank:

This is to advise you that your request for reconsideration of the decision to disapprove California State Plan Amendment 83-14 was received on February 16, 1984. You have requested a reconsideration of whether this plan amendment, which would revise the Medically Needy Income Level for determining Medicaid eligibility for a family of two adults, conforms to the requirements for approval under the Social Security Act and pertinent Federal requirements.

I am scheduling a hearing on your request to be held on May 8, 1984, at 10 a.m., in Room 26A, 100 Van Ness Avenue, San Francisco, California. If this date is not acceptable, we would be glad to set another date that is mutually agreeable to the parties.

I am designating Mr. Lawrence Ageloff as the presiding official. If these arrangements present any problems, please contact the Docket Clerk. In order to facilitate any communication which may be necessary between the parties to the hearing, please notify the Docket Clerk of the

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names of the individuals who will represent the State at the hearing. The Docket Clerk can be reached at (301) 594-8261.

Sincerely yours,
/s/ CAROLYNE K. DAVIS
Carolyne K. Davis, Ph.D.

Intervenors' Exhibit 13

Department of Health and Human Services
Health Care Financing Administration

Docket No. 84-6

IN THE MATTER OF CALIFORNIA STATE PLAN
AMENDMENT NO. 83-14

DECLARATIONS OF: Alma Bales, Donald A. Barrier, Allan Bierman, James Jones, Ronald Kwiek, Loretta McParland, Donald Minor

---

DECLARATION OF ALMA BALES

I, Alma Bales, declare:

1. I live with my husband at 3850 Callan Boulevard, in South San Francisco. The matters contained in this declaration are within my personal knowledge, and if called as a witness, I could competently testify thereto.

2. Both my husband and I are 65 years old. Our total income consists of social security benefits. I receive $355 and my husband receives $575 per month.

3. I have cancer of the throat. It was diagnosed about two years ago. At that time, I had laser surgery in San Francisco at Children's Hospital. The cancer was not cured, however, and I again had surgery one year later at Stanford University Medical Center. That surgery was followed by six months of daily radiation therapy, which I had at Stanford. Recently, the doctors have stopped the radiation treatments, since they have left me quite exhausted and ill. I have incurred medical bills of thousands of dollars for these treatments.

4. My husband has high blood pressure. He has suffered three strokes, the first in 1972, the second in approximately 1973, and the third only recently. All three strokes were on his right side. He walks with great difficulty, using a cane. He must control his high blood pressure with

medications and a special diet. In addition I try to take him to the doctor at least every other month. To date, we have been paying for these medical expenses ourselves.

5. We receive Medi-Cal with a share of cost. At the moment, our share of cost is $356. However, I am advised that the San Mateo County Welfare Department has erroneously failed to increase our maintenance need level to $709, so that our share of cost should be $201. I am in the process of trying to correct this problem.

6. I have received bills from Stanford Medical Center for my radiation treatments and surgery. The bills, as I have already stated, are for thousands of dollars of care. The hospital is investigating to determine why the bills have not been paid by Medi-Cal. At some point, we will have to pay the hospital for our share of cost. I expect that Medi-Cal will pay the remainder of the bills.

7. We cannot afford a monthly share of cost of $356. Our rent alone is $269. Our PG&E bills run about $18, and our telephone bill is $30 per month. We have very high food bills (about $240 per month), because both my husband and myself need special diets because of our medical conditions. We have a ten year old car, which uses quite a lot of gas. At the time that I was going to Stanford daily, (a round trip of 50 miles from my home), we were paying at least $50 per month for gasoline. We also have expenses for laundry and dry cleaning, car insurance, and items of clothing which need replacement. As it is, we have barely enough money to meet our living expenses. Frequently, we run out of money at the end of the month, before our bills are paid.

8. We will have serious financial difficulties in paying off our bill to Stanford. It is some comfort that the bill will be only $201, rather than $356, per month. It is very difficult dealing with the emotional and physical problems associated with cancer, without having to worry also about medical bills which we will never be able to pay.

I declare under penalty of perjury that the foregoing is true and correct, and was executed in South San Francisco, California.

DATED: March 30, 1984

/s/ ALMA BALES
Alma Bales

DECLARATION OF DONALD A. BARRIER

I, Donald A. Barrier, declare that the matters stated herein are within my personal knowledge, and if called as a witness, I could testify competently thereto:

1. My wife and I live in Chico, in Butte County, California. I am 57 years old. I have been completely disabled for slightly over nine years. At age 48 I suffered several strokes and epileptic seizures caused by a severe malformation of the arteries in the left side of my brain. The seizures which accompanied the strokes caused several (ten at present) thoracic spinal compression fractures. I am also afflicted with osteoporosis which, besides causing severe discomfort, has caused pinched nerves in my spinal column, making walking without a cane extremely difficult. I have grand mal epileptic seizures which, in addition to causing compressed fractures, can be fatal (through asphyxiation) if not controlled by medication. I am constantly in pain because of severe headaches caused by the arterial malformations and from the spinal trauma I have suffered. I also have angina pains, the cause of which is presently uncertain. I must take medications and be under constant periodic medical supervision if I am to survive. I am on Medicare and Medi-Cal. I currently have no share of cost for Medi-Cal.

2. I have been married for 37 years. My wife does not work, as taking care of me is a full time job. Our total monthly income is $637, of which $587 is Social Security disability and $50 is Veterans Administration disability. Our rent and utilities are $200 per month. Automobile gasoline and maintenance averages $59 per month, home repairs and maintenance $20 per month. In my condition, having a car is absolutely necessary, for trips to the doctor and to the hospital in the event of an emergency. I must also make periodic trips to the Veterans Hospital in San Francisco. Clothing expenses average about $15 per

month. Food and groceries run about $260 per month. Insurance, licenses and miscellaneous taxes cost us $51 each month. In addition we must spend an average of $10 per month on non-precription drugs and medications and $7 per month on prescription drugs not covered by Medi-Cal. Dental care and eyeglasses cost us another $15 a month, on the average. My wife does not receive Medi-Cal, so we must pay cash for her doctor and dental visits, eye examinations and eyeglasses.

3. It is rare to find medical doctors in our area who will accept Medi-Cal. Hospitals and pharmacies will accept Medi-Cal, which enables me to survive. Medi-Cal now pays for my prescription drugs which amount to approximately $60 per month. It has also paid for hospital tests which in the past year would have averaged at least another $60 per month. I take Mysoline and Codeine on a daily basis, which as of now are paid for by Medi-Cal. I also take, at less frequent intervals, Nitroglycerine, Valium and Motrin, which Medi-Cal does not pay for. If it became necessary for me to assume any share of cost for Medi-Cal, I don't think that I could survive either physically or financially. As you will note, our expenses currently equal our income.

I declare under penalty of perjury that the aforesaid is true and correct and was executed in Chico, California, on March 26, 1984.

/s/ DONALD A. BARRIER
Donald A. Barrier

DECLARATION OF ALLAN BIERMAN

I, ALLAN BIERMAN, declare that the matters stated herein are within my personal knowledge, and if called as a witness, I could testify competently thereto:

1. My wife and I live in Copperopolis, in Calaveras County, California. I am 67 and my wife is 69 years old. I have a severe heart condition; I have had open heart surgery and have artificial valves and a pacemaker. My wife has lung cancer. Consequently, we have very high medical expenses. My wife recently had to be hospitalized in San Mateo for seven (7) days. The hospital bill was over $15,000. Our combined Social Security, which is our sole source of income, is $955 per month. We currently have a $219 Medi-Cal share of cost. This leaves us with $736 to meet our expenses and pay off our debts.

2. Our house payments are $439 per month. We pay an average of $150 per month for electricity, because we live in a rural area where all utilities, including our well pump, are electric. Our phone bill is about $25 per month, and gas for our car costs us about $70 per month. We then have to spend for groceries and insurance. I use a walker, which costs $75 per month to rent. Medi-Cal used to cover the entire cost of the walker, but now only pays part of the cost. Without it, I can't get around. I also need pure oxygen, a tank per week, because of my heart condition. Oxygen costs $50 a tank, most, but not all of which is paid by Medicare.

3. Our medical bills, with our medications, average around $150 per month. Some months they are as high as $400 to $500. We are currently in debt over $1,600, and I don't know how we will pay that off. With out income and expenses we have nothing left over, but in fact go further in the red each month. We only spend for the bare necessities; we can afford none of the "extras."

4. If our Medi-Cal share of cost were to increase, I don't see how we could meet the cost. To forego my oxygen or medications would put me in a life threatening situation. If my wife were to forego any part of her lung cancer treatment, her life would certainly be in jeopardy.

I declare under penalty of perjury that the aforesaid is true and correct and was executed in Copperopolis, California, on February 16, 1984.

/s/ ALLAN C. BIERMAN
Allan Bierman

DECLARATION OF JAMES JONES

I, James Jones, declare that the matters stated herein are within my personal knowledge, and if called as a witness, I could testify competently thereto:

1. I live with my wife, Bessie Mae Jones, in Berkeley, Alameda County, California. My wife and I are 61 years old.

2. I am disabled by severe arthritis in my back and a chronic heart condition. I am on Social Security Disability, and receive $521 per month. My wife works as a substitute teacher in Berkeley and Oakland. Her income varies between $100-$200 per month, depending upon how often she is called to work.

3. My wife has diabetes and a severe sinus condition. I am covered by Medicare as well as Medi-Cal because I am on Social Security Disability, but my wife is not. She goes to the doctor two to three times monthly, for blood sugar tests and treatment of her sinus condition. She takes Drixoral daily for her sinuses, which costs $23 for 100 tablets. She also takes Diabinese for diabetes, and is on a special, no-sugar diet. The diabetic foods she must have are very expensive.

4. In or about 1976, I had a heart attack. In or about 1979, I had another one. Both times, I was in the hospital for several weeks. For my heart condition and arthritis, I take potassium cholride, Digoxin, Lesix and Prednisone daily. I also take Tylenol and vitamin C daily, which Medi-Cal does not cover. In addition, I go to the doctor at least every six weeks to monitor my medical condition.

5. My wife and I own our home in Berkeley. Our mortgage payments are $373 per month. Our utilities, including PG&E, water and garbage, run about $100 per month. Our grocery bill is about $125 per month—high because of my wife's expensive diabetic foods. Our telephone bill is about $40 per month. Insurance, transportation, clothing and other incidental expenses also

come out of our income, which varies from about $620-$720 per month. Some months we are a few dollars ahead, some months a few dollars behind. If we had any higher share of cost on Medi-Cal, we would have to cut back on food or doctors' visits, in order to make ends meet. I cannot do without my medications, but I could not afford to pay for them myself. It would be also very dangerous for my wife to do without proper medical care, as her diabetes must be monitored constantly. Her health is poor now, but if she gets so sick that she can't work at all, we will be in much worse shape financially.

I declare under penalty of perjury that the aforesaid is true and correct and was executed in Berkeley, California, on 4-4-1984.

/s/ JAMES C. JONES

James Jones

DECLARATION OF RONALD KWIEK

I, Ronald Kwiek, declare that the matters stated herein are within my personal knowledge, and if called as a witness, I could testify competently thereto:

1. My wife and I live in Angwin, in Napa County, California. I am 41 years old and have had Multiple Sclerosis (M.S.) for the past thirteen years. I am subject to frequent bladder-kidney (G.I.) infections and pneumonia, which have put me in the hospital on numerous occasions. I have been hospitalized 32 times since 1978, each time for approximately seven days. Most recently I was hospitalized from December 1983 to late March 1984, during which time I underwent two surgeries.

2. I receive $719 per month from Social Security. My wife works as a teacher part-time during the school year. During those nine months her monthly income varies from $250 to $550. Our Medi-Cal share of cost therefore varies a great deal, going as high as $324 when my wife is working the greatest number of hours. In January and February 1984, our share of cost was $212. In March it was $95.

3. I receive Medicare as well as Medi-Cal. Because I have been hospitalized so frequently, I have used up most of my Medicare hospitalization coverage. I have used up 11 days of the 60 day lifetime reserve of Medicare covered hospital care. The hospital insurance department has recommended that, instead of using up my lifetime reserve, I pay the share of cost and go on Medi-Cal, which I have done since December. Therefore we are paying our entire share of cost to the hospital each month that I must be in the hospital.

4. Our regular monthly expenses total, on average, $820. We pay $375 per month in rent, utilities $50, phone $60, garbage $10, car $25, credit union payments $30, food $150, and clothing and supplies $120. Maintenance expenses for our car and my wheelchair add another

$200-$300 per year onto our expenses. I require Home Health and Physical Therapy follow-through care each time I return home from the hospital. Medi-Cal no longer covers these expenses; Medicare pays 80% and we pay the remaining 20%. My medications, for maintenance of G.I. tract infections and other problems connected with M.S., cost $30 per month. When I am not in the hospital I must make weekly visits to the doctor for urinalysis and check-ups.

5. Because my medical expenses are so high, almost all of my wife's salary is spent meeting our share of cost. It is very difficult to save any of her salary for the summer months when our sole source of income is my $719 in Social Security. Our expenses exceed the current $709 maintenance need level, and they reflect a bare minimum: my medical supplies, which cost about $1,000 per year, are absolutely necessary. We must have a car, as I am confined to a wheelchair, and there is, in any case, very little public transit in our area. If our maintenance need level were decreased we simply could not meet our share of cost. My ability to receive absolutely necessary care for recurrent G.I. infections, pneumonia, and other complications arising from M.S. would be in serious jeopardy, and with it my life.

I declare under penalty of perjury that the aforesaid is true and correct and was executed in Angwin, California, on March 23, 1984.

/s/ RONALD KWIEK

Ronald Kwiek

DECLARATION OF LORETTA McPARLAND

I, LORETTA McPARLAND, declare:

1. I live with my husband, Hubert McParland, at 2027 V Street, Merced, California.

2. I am 59 years old and my husband is 63. My husband suffers from heart problems and had open heart surgery in 1976 and again in 1980. He suffered a major heart attack in 1983, for which he was hospitalized 17 days. Hubert also suffered from bladder cancer, until he had a urostomy in 1980. The urostomy means that he periodically suffers infections in his abdominal area and he must constantly wear urine bags.

3. Hubert visits his internist at least once per month and more frequently if necessary. He also visits a urologist at Stanford University Hospital, about 130 miles from our town, every four to six months, and we must pay for transportation costs. He takes digoxin as a heart medicine, vasodilan for blood circulation, inderal for high blood pressure, lorelco for cholesterol, and he keeps some nitroglycerine tablets on hand at all times. Every 24 hours, he is required to use a nitroduro patch directly on his skin to prevent chest pains. Hubert's urostomy bags must be replaced anywhere from 10 times a month to twice a day, depending on the weather, his fluid intake or infectious conditions. To attach his urostomy bags, he must use about ten 4 by 4 patches each month and numerous medicated wiping pads. With a urostomy, Hubert's kidney functioning must be kept up, so he is required to drink large quantities of fruit juices. I buy him, in addition to other juices, 48 oz. bottles of cranberry juice, which he drinks in about two days' time. Each bottle costs close to $2.00. Also, his heart condition requires that his diet consist of chicken and fresh fish and vegetables, but no fatty foods. I cannot make casseroles or food dishes that can be made in quantity and frozen or that in other ways stretch our food money because they require fatty or high

cholesterol foods that Hubert is not allowed to eat. For instance, Hubert is not supposed to eat creamed tuna or meatloaf, which are budget dishes. These are the kinds of meals I was used to making for years in order to feed a family of six. As a result of Hubert's special diets, we must spend a lot of our money on food. I must buy a lot of fresh fish, which is not easy to find in Merced. Often I must shop at a specialty fish store which is expensive. Finally, Hubert's medical condition makes him especially prone to colds, flu, and infection, and he also needs more careful treatment for these common illnesses than do persons without his medical problems.

4. I have hypoglycemia and a thyroid condition. I also am supposed to be on a special diet. Ideally, I am supposed to have a doctor's examination every three months, but we have not been able to afford it. I take thyroid medicine daily. I have been prescribed premarin, but I have not purchased it because we cannot afford it. I have recently experienced dizzy spells, when I nearly fainted. My doctor has informed me that I need blood tests to check my blood sugar and cholesterol levels, but I have not obtained them because we cannot afford them. To me, Hubert's condition seems more life-threatening, so his medical needs come first in our budget.

5. Our main source of income is Hubert's Social Security disability insurance, which is $637 per month. He also receives a small Teamsters Pension of $66 per month and a Veterans Administration pension of $24. Our total monthly income is $727. I have no income. Currently, our monthly expenses are:

House* – insurance and taxes	$ 72.00
Gas, electricity, telephone, water and garbage	104.00
Food	250.00
Clothing and household goods (Sears and Mervyns time payments)	61.00

Medicine not covered by Medi-Cal ($80.00) and back medical bill payments ($30)	110.00
Gas, car repair and maintenance, car insurance	125.00
	$722.00**

*We paid our final house payment in September, 1983.
**Compare to our income of $727.00.

6. Currently, Hubert receives Medi-Cal at zero share-of-cost because Merced County has determined our monthly net nonexempt income to be slightly less than the maintenance need level of $709.

7. Until the fall of 1982, we received Medi-Cal at shares-of-cost varying from zero to $40 to $240. Then in about September, 1982, we received a notice that our share-of-cost for Medi-Cal had risen to $359 per month. Our worker explained that Medi-Cal expected us to live on a certain maintenance need level, and that all of the rest of our money, $359, had to go for medical payments before we could get Medi-Cal. At the time, our income was about $705, and we could not possibly have lived on the remaining $346 per month. Our house payment was $150 and our utilities averaged $90. Each month we used the rest of our money to buy food, clothing, and personal and household supplies. We also had considerable transportation expenses, but we used our car only for medical visits and grocery shopping. At the same time, some of Hubert's medicines were no longer covered by Medi-Cal. His cholesterol pills, lorelco, cost about $36 per month; his nitroduro patches, at least $34; and his vasodilan, about $6. Altogether, we usually spent $80 or more each month on medicines and medical supplies that were not covered by Medi-Cal. Mostly, I suffered when the share-of-cost

was high. I did not got to the doctor during the entire year, nor did I buy my prescription medicines, which were not covered. We incurred substantial medical bills to hospitals, doctors and pharmacies during this time. And finally, we were not able to spend the money on food to eat what our special diets required.

8. In about November, 1983, our share-of-cost was reduced back to zero. My legal aid attorneys have informed me that this happened because a new state law and a lawsuit changed the maintenance need level from $544 to $709, so that we had no more share-of-cost. They have also informed me that the federal government may force California to go back to the old maintenance need level and higher shares-of-cost. If we went back to having to live on $544, we would have all of the same problems all over again:

a. we would have to violate our special medical diets;

b. I would have to cut out my medical care entirely;

c. we would be incurring larger and larger medical bills for Hubert's care, and we would not be able to make payments on any of the back bills (although we have been trying to make monthly payments, we still have outstanding medical bills amounting to about $900, as a result of the high share-of-cost before);

d. we would have to cut back on the use of our car, although we now rarely use it for anything other than medical visits and grocery shopping; and

e. we would have to choose between buying food and buying medicines.

I declare under the penalty of perjury that the foregoing is true and correct.

/s/ LORETTA MCPARLAND

Loretta McParland

DECLARATION OF DONALD MINOR

I, Donald Minor, declare:

1. I live with my wife, Imogene, and my 19 year old son, Paul, in Dublin, California. The matters stated herein are within my personal knowledge, and if called as a witness, I could testify competently thereto.

2. I am 58 years old, and suffer from a serious heart condition, diabetes, and hypertension. In addition, I have had surgery for cataracts, and without special glasses, I am virtually blind in both eyes. I have had five heart attacks. The last one was a cardiac arrest, from which I almost died.

3. I am required to see a doctor at least every three months, and more if necessary, to monitor my condition. I take four heart medications every six hours and three other pills once a day. I also use insulin twice a day. The cost of these medications is about $140.00 per month. In addition, I should be eating a special diet both because of my diabetes and my heart condition. Finally, I see an opthamologist every six months to monitor my eye problem.

4. My family's sole source of income is Social Security Disability Insurance, which I have received for about seven (7) years. I receive $727.00 per month for my wife and myself, and my son receives $161.00. Until June 1, 1983, we received Medi-Cal coverage without any cost. One medication which costs about $11.00 was not covered. All my other medical expenses were paid for by Medi-Cal.

5. In September, 1982, I received a notice from the Alameda County Welfare Department informing me that my family's share of cost for Medi-Cal would be $279.00, starting on October 11 that share of cost was based on a maintenance need amount of $589.00. We could not possibly have lived on $589.00 a month. Our rent is $300.00, our utility bill goes from about $100.00 in warm months to as much as $160.00 in cold months, our water

bill is $49.00 every two months, and our garbage bill is $38.00 every three months. The remaining money, every month, is used to pay our telephone bill, and to buy food, clothing, and other necessary items. As it is, by the end of the month we frequently do not have any money for food. Although I am not supposed to eat large amounts of starch, or foods high in cholesterol, by the end of the month we generally can only afford eggs or spaghetti.

7. Since we live in Dublin, where bus service is very inadequate, and my doctor is in San Leandro, we must have a car. We try to use no more than two tanks of gas a month. We cannot afford insurance at all. If the car needs new tires or a repair, we have to go hungry.

8. It is essential that I be able to receive Medi-Cal benefits, since I cannot afford my medical expenses myself. Our new share of cost made it impossible for me to do that. As a result, I requested a fair hearing to contest the share of cost. I was also a plaintiff in a lawsuit, called *Minor* v. *Myers* No. C-82-5974-SW (N.D. Cal.). My attorney, Evelyn R. Frank informs me that the purpose of the lawsuit was to force the Department of Health Services to use the same maintenance need standards for medically needy families as it was using for aged, blind and disabled people. She also informs me that, after the lawsuit was filed, new regulations were issued, which did increase the maintenance need for medically needy families. As a result of those regulations, my family's share of cost was increased to $193.00 per month, instead of $279.00, effective June 1, 1983. (See Exhibit A, hereto).

9. Since June, I have not been able to meet the $193.00 share of cost. As a result of the confusion in my Medi-Cal coverage and the lack of stickers since June, I missed several regular doctor's appointments, because I was not able to pay for them. I did go to the doctor on August 12, which cost $38.00. The last time I bought medicine in early August, I spent $106.00, which was for just part of the

medications I needed. I could not afford the rest. In July, I almost ran out of insulin. Also, my wife had a doctor's appointment because she has a painful lump in her breast. That one appointment cost $75.00. We live from check to check, never knowing when I will be unable to get the insulin which I need in order to avoid a diabetic coma. I am also very worried, since I do not know how I will continue to get the medical attention which I should have to avoid further heart problems.

10. My attorney has informed me that the Legislature passed a new law, which would raise our maintenance need to $708.00 per month, if we took our son out of our Medi-Cal budget unit. Since our share of cost would be 0, we would definitely elect to take our son out of our Medi-Cal case, so that I could go to the doctor and get my medications. I respectfully ask this court to issue an order requiring the Department of Health Services to implement the new law as soon as possible. For me, this may be a matter of life or death.

11. Within one year prior to the date of this declaration, I have paid a tax to the State of California.

I declare under penalty of perjury that the foregoing is true and correct, and was executed in Dublin, California.

DATED: August 26, 1983

/s/ DONALD MINOR
Donald Minor

INTERVENORS' EXHIBIT 13A

UNITED STATES DEPARTMENT OF
HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

Docket No. 84-6
Reconsideration Hearing

IN THE MATTER OF:
CALIFORNIA STATE PLAN
AMENDMENT NO. 83-14

DECLARATION OF SALVADORA VASQUEZ

I, Salvadora Vasquez, declare that:

1. I live with my husband, Mike Vasquez, at 1156 San Luis, Apt. 90, Los Banos, California.

2. I am 62 years old and my husband is 63. My husband has been a kidney dialysis patient since about 1976. He is nearly blind, but he just had a cataract operation on June 19, 1984. Mike's right leg below the knee and one of his left toes have been amputated. He also suffers from diabetes.

3. Mike has kidney dialysis three times a week, on Tuesdays, Thursdays and Saturdays, at the Satellite Dialysis Center in Modesto, California, about 60 miles from our home in Los Banos. A van picks him up at 9:00 A.M. on those days and returns him home at about 7:30 P.M. He is in a wheelchair most of the time, but uses a walker around our apartment. Sometimes Mike gets infections where his leg was amputated, and he must get medicine and gauze pads to treat them. I also buy jars of Lanalor cream for his legs, on the recommendation of his

doctor. This cream costs $12.00 per jar. He takes insulin in tablets for his diabetes from time to time. He has also been prescribed folic acid and vitamins.

4. I have diabetes, arthritis, heart trouble and high blood pressure. I must give myself insulin injections twice a day. My arthritis causes me pain from my knees to my hip, and I often must walk with a cane. I have very poor balance. My hands are so painful that I cannot use them very well. Often I cannot pick up a skillet. I have had my gall bladder removed, have had surgery for varicose veins twice, and suffer from recurrent bladder infections. I have a disability application pending.

5. For my diabetes, I inject 30 cc. of Nph Iletin I (100 units/cc.) in the morning and 20 cc. in the evening. I inject 10 cc. of Regular Iletin I (100 units/cc.) in the morning and 5 cc. in the evening. I must have a sufficient number of syringes to do this every month. For my arthritis I take 2 parafon forte tablets four times a day. These cost about $22.00 per month. I also take Tylenol, which costs about $4.00 a month. For my heart trouble, I take .25 mg of lanoxin every morning. To lower my blood pressure, I take dyazide twice daily. When I have other health problems, such as bladder infections, I must take medicine for them also. Despite my own health problems, I have spent much of my time the last few years caring for my husband and, before the van was available, taking him to his dialysis treatments.

6. Both Mike and I are suppose to be on special diets, mostly to control our diabetes. We are supposed to eat vegetables and fruit but very little meat. We are not supposed to eat tortillas, potatoes, macaroni or more than 2 slices or bread. We cannot afford to follow this diet. For instance, we are supposed to eat fish three times a week. We are not able to afford to do this, except sometimes in the first week of a month after our money comes. I sometimes make a tuna casserole for the fish, but it usually has macaroni or other starchy foods in it that we are not sup-

posed to eat. I also fix bologna sandwiches, even though the bread, the meat, and the salt are bad for us. We have cut down on tortillas, but we still eat potatoes.

7. Our source of income is Mike's Social Security disability benefits, which are $580 a month. Until April, 1984, when I turned 62, we had no other income. Now, I get a Social Security check of $219 a month. Our total monthly income is now $799. Currently, our monthy expenses are:

Rent	$147.00
Gas, electricity and telephone	96.00
Food	225.00
Medicines and medical supplies not covered by Medi-Cal	80.00
Laundromat	15.00
Household and personal hygiene supplies	80.00
Gas, car repair, car insurance	137.16
Household goods (McMahan's installment payment)	23.00
	$803.16*

*Compare to income of $799.

Before I began receiving a Social Security check, our income was only $580. However, the apartment we live in is subsidized housing, so our rent was considerably lower then. We did not then have a Medi-Cal share-of-cost, and we were not able to buy as much food or as many personal or household items. We still have not brought clothing, underwear or linens for about 9 years, and the things we have are wearing out.

8. Currently, Mike receives Medi-Cal after a $70 share-of-cost. Before I got a Social Security check, Mike had a zero Medi-Cal share-of-cost because Merced County

determined our monthly net nonexempt income to be considerably less than the maintenance need level of $709 for two adults.

9. My legal aid attorneys have informed me that a state law and a lawsuit established the maintenance need level at $709 instead of $544. They have also informed me that the federal government may force California to go back to the old maintenance need level and higher shares-of-cost. If we had to live on $544, which is even less than the $580 just my husband used to get, our share-of-cost would take $235 each month. Our rent would not go back down to the $90 it was when we only received $580; even though our share-of-cost would be high and we would have less to live on, our rent would stay at the new higher rate. My husband would have to continue his dialysis treatments, so we would have to cut back severely on food, personal supplies, and transportation. I would not visit my doctors in Merced, about 35 miles away, and we would eat foods which are not on our special diets.

I declare under the penalty of perjury that the foregoing is true and correct.

Executed on July 7, 1984, at Merced, California.

/s/ SALVADORA S. VASQUEZ

Salvadora Vasquez

INTERVENORS' EXHIBIT 17

DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

Docket No. 84-6

IN THE MATTER OF
CALIFORNIA STATE PLAN
AMENDMENT NO. 83-14

DECLARATION OF ASSEMBLYWOMAN MOORHEAD

I, Jean Moorhead, declare:

1. I am the duly elected Assemblywoman from the Fifth Assembly District, which includes portions of Sacramento and Placer Counties. I am the Chair of the Assembly Committee on Aging and Long Term Care. The matters contained in this declaration are within my personal knowledge, and if called as a witness, I could competently testify thereto.

2. In June, 1982, the California Legislature passed a Medi-Cal Reform bill, known as AB 799, 1982 Stats. Ch. 328. That bill repealed Welfare and Institutions Code § 14005.13, which had provided a Special Income Deduction allowing medically needy single adults and couples to keep as much income as SSI recipients to meet their non-medical needs. AB 799 also enacted a new formula for setting the medically needy income level (MNIL) in California. As a result of that formula, which based the MNIL's for the aged and disabled on 133-⅓% of the AFDC grant for one or two persons, single adults were required to meet their non-medical needs on $331 per month, and adult couples were required to live on $544 per month. In con-

trast, SSI recipients received $451 for a single person, and $838 for a couple. Medically needy aged and disabled people experienced a very sharp increase in the share of cost which they were required to meet each month in order to qualify for Medi-Cal.

2. During the early part of 1983, the Assembly Committee on Aging and Long Term Care held public hearings in four cities to take testimony on the effect of the changes in California's Medi-Cal program accomplished by AB 799. The first hearing was held in San Diego on February 4th, the second in Oakland on February 25th, the third in Los Angeles on March 18th, and the fourth in Eureka on April 8th.

3. In each of those hearings there was a great deal of testimony from advocates, medical providers, and from aged and disabled people themselves, regarding the tremendous increases in the share of cost which had occurred as a result of AB 799's repeal of the Special Income Deduction. Many of those affected suffered from serious illnesses such as cancer, heart disease, and crippling arthritis. Some witnesses testified that these people were unable to go to the doctor and unable to obtain needed prescription medications, because they could not afford to pay for those needs themselves and could not meet their new share of cost. Others testified that seniors and disabled people were being forced to do without adequate food, in order to pay for necessary medical treatment. A nutritionist testified that 50% of the diseases prevalent among the elderly are related to malnutrition, and that more than 50% of the elderly have substandard diets. This situation was being exacerbated by the increase in the share of cost. (Eureka Hearing at 78-80). One woman testified that, because of the increased share of cost, she was forced to put her husband into a nursing home, because she could not afford to pay for their non-medical

needs and also to pay the share of cost for his medical care. (Los Angeles Hearing at 41-45).

4. The testimony which the Committee heard demonstrated, without exception, that elderly and disabled adults could not meet their most basic needs on $331 for a single person, or $544 for a couple. I submit with this declaration the transcripts of the hearings, and particularly direct the Hearing Officer's attention to the pages listed in the Appendix hereto.

5. In addition to the testimony taken at the public hearing, my office was flooded by letters and phone calls from people who found themselves unable to qualify for Medi-Cal because of the increase in their share of cost. Also, my office received thousands of signatures on a statewide petition which was circulated by the Gray Panthers and other groups, urging an increase in the MNIL's. I am aware that many other legislators received similar communications from their constituents.

6. As a result of the testimony and the large number of complaints, many legislators, including myself, realized for the first time the impact which the new increase in the share of cost would have on aged and disabled people who depend on Medi-Cal as a means of getting necessary medical treatment.

7. Several bills were introduced to try to deal with the problems caused by the increase in the share of cost. Ultimately, AB 963, authored by Assemblyman Agnos, became the main focus of legislative attention, because it provided a formula which would increase the maintenance need amount for medically needy single aged and disabled people and for couples to a level which, while still inadequate, might allow them at least to obtain sufficient food, decent shelter, and other basic necessities. It did so by basing the MNIL for a single person on the AFDC grant for two, and by basing the MNIL for an adult couple on the AFDC grant for three. The Legislature thereby recognized

that elderly and disabled adults frequently incur greater living expenses than is the case for families with children, because of their need for such things as special diets, and because of their generally more frail condition. I was a principal co-author of the bill in the Assembly. The breadth of support for the bill can be seen from the fact that it also had thirteen other co-sponsors in the Assembly. In the Senate, the principal co-author was a Republican, Senator Seymour, and there were six additional co-authors. The bill's provisions were included in the budget trailer bill, 1983 Stats. Ch. 323, and were thus enacted into law on June 21, 1983.

I declare under penalty of perjury that the foregoing is true and correct and was executed in Sacramento, California.

DATED:

/s/ JEAN M. MOORHEAD
Assemblywoman Jean Moorhead

APPENDIX:

Testimony at State-Wide Hearings From Adult Couples Affected By Increase in Share of Cost

(Page number indicated is first page of witness' testimony)

San Diego Hearing, February 4, 1983

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3	Paul Chapman
20	Mary Wilson
33	Mrs. Warren Van Branken
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65	Max Sparer
82	Jane Dumas
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Oakland Hearing, February 25, 1983

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3	Alan Butts
24	Ronald Kwiek (See also p. 122a-q)
38	Loyde Cade
61	Joel Resnikoff
64	Marty Lynch
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122E	Jerry Casson

Los Angeles Hearing, March 18, 1983

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41	Daisy Bell (see also p. 122B)
77	Lourdes Birba
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AA19	Various Dialysis Patients

Eureka Hearing, April 8, 1983

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61	Billie Rogers
70	Elizabeth Lee
78	Mary Pinchini
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E1	Alfred Abernathy

Transcript of Proceedings

BEFORE THE
UNITED STATES DEPARTMENT OF
HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

Docket No. 84-6
Reconsideration Hearing

IN THE MATTER OF
CALIFORNIA STATE PLAN
AMENDMENT NO. 83-14

TESTIMONY OF BRUCE CAMPBELL

DATE: July 2, 1984
PLACE: San Francisco, California
PAGES: 1-87

[56] Q [Ms. Frank] Showing you what has been marked and admitted as Intervenor's Exhibit 5, are you familiar with this document?

A Yes.

Q When did you first see it?

A When it came back from our headquarters, Bureau of Eligibility, Reimbursement and Coverage. The date is April 15, 1983, so I would assume, you know, within a matter of couple of days.

Q All right.

And this was the response to the inquiry in the previous exhibit, was it not?

A Ma'am, it's from Bureau of Eligibility, Reimbursement and Coverage.

Q Now, Mr. Oday, I gather, is the Director of that bureau?

A He was.

Q He was at the time?

A Right.

Q And as far as you were concerned was his opinion binding on the Regional Office in matters of policy interpretation?

A I would prefer to say binding on me.

[57] Q Binding on you.

A The reason I say that is because we make—as program people we don't have the authority to approve or disapprove State Plan Amendments. We don't have the authority unless it's been specifically delegated to the Regional Administrator by the Administrator to speak. So, in other words, in our predecisional documents back and forth, until the decision is made by HCFA headquarters back there, you know, and—we send the ideas back and forth.

Q Now, when you say HCFA headquarters do you include in that Mr. Oday?

A Pardon?

Q When you say HCFA headquarters do you include in that Mr. Oday?

A No, when I'm speaking of headquarters, to be honest, ultimately I'm speaking of up through the Administrator.

Q But as far as matters of policy this—as far as you were concerned—was the policy of the agency, is that correct?

A That's what I assumed.

(Pause.)

Q And you communicated that response to the State, did you not?

A Yes, I did.

[58] Q To Carol Goodman, is that correct?

A Yes.

Q Now, I'm going to show you—you have in your hand—

HEARING OFFICER: I'd like to interrupt for a moment.

MS. FRANK: Yes?

HEARING OFFICER: I'd like you to go back to Intervenor's Exhibit 5, the Oday memo. How do you interpret the last sentence of the second paragraph – next-to-last sentence, excuse me – "We are currently in the process of clearing regulations which reflect this interpretation through HCFA and the Office of General Counsel for eventual publication in the Federal Register."

What does that mean to you as a program person?

THE WITNESS: As a program person that would mean to me that HCFA is about to take an action which central office would know about, which I as a regional person would not be aware that it's in the process of doing something.

HEARING OFFICER: Does it indicate to you that the position in here was not a final position and it had to be cleared by the Office of General Counsel?

(Pause.)

THE WITNESS: I'm sorry, could you repeat that?

HEARING OFFICER: Does that sentence indicate [59] to you that this is not a final agency position, but rather a proposed position that has to be cleared by the Office of General Counsel?

THE WITNESS: Yes.

HEARING OFFICER: Was it your understanding that agency policy involving the interpretation of the statute has to be cleared by the Office of General Counsel?

THE WITNESS: Yes, sir.

HEARING OFFICER: Go ahead.

BY MS. FRANK:

Q Now, when you had the discussions with Carol Goodman did you – and you stated that you informed her that it would be HCFA's policy that TEFRA would invalidate the adult couple maintenance need level, did you advise her that that had yet to be cleared by the Office of General Counsel?

A I said I assumed that that's what would be happening. I don't think I specifically advised her of that. In other words, I advised her that this was what I had gotten back.

Q So you advised her that you had been informed that the agency policy was that this would violate TEFRA?

A That's correct.

[85] * * * * *

BY MR. JOHNSON:

Q Bruce, directing you—I believe it is—to Exhibit 8, Intervenor's Exhibit 8, the letter O'Hara wrote on or about August 23 to Doris Soderberg.

(The document was proffered to the witness.)

A Yes?

Q At the time—you prepared this letter also for Mr. O'Hara's signature—

A Yes, I did.

Q —like you had with Exhibit 4, the letter in March?

A I'm sorry, which was Exhibit 4?

Q That was the one in March.

HEARING OFFICER: Was that the O'Hara memo back to Washington?

MR. JOHNSON: Yes, the O'Hara letter that went to Washington.

THE WITNESS: Right.

BY MR. JOHNSON:

Q And you had received a letter back from Oday telling you that that had to—that it may very well violate [86] but we have regulations in the process and it has to go through General Counsel's Office before anything final can be done. Now, when you sent that letter—or, when O'Hara sent this letter—on August 23rd you had never received any final clearance from the Office of General Counsel, had you?

A That's correct.

MR. JOHNSON: That's all I have.

HEARING OFFICER: Ms. Kohn?

MS. KOHN: I just have a couple, and one follow-up question.

REDIRECT EXAMINATION

BY MS. KOHN:

Q Mr. Campbell, was the State—or did you ever tell anyone from the State that if they were to submit a methodology for factoring out the adult couple MNIL from their program that TEFRA would preclude the proposed amendment?

A No.

Q One other question: Who makes the final initial determinations approving or disapproving State Plans?

A The Administrator of HCFA.

* * * * *

In the Supreme Court of the United States

OCTOBER TERM, 1986

No. 86-863

OTIS R. BOWEN, SECRETARY OF HEALTH AND HUMAN SERVICES, PETITIONER

v.

STANLEY CUBANSKI, DIRECTOR OF THE CALIFORNIA DEPARTMENT OF HEALTH SERVICES, ET AL.

ORDER ALLOWING CERTIORARI. *Filed February 23, 1987.*

The petition herein for a writ of certiorari to the *United States Court of Appeals for the Ninth Circuit* is granted.

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Supreme Court, U.S.
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JOSEPH F. SPANIOL, JR.
CLERK

No. 86-863

In the Supreme Court of the United States

OCTOBER TERM, 1986

OTIS R. BOWEN, SECRETARY OF HEALTH AND HUMAN SERVICES, PETITIONER

v.

KENNETH KIZER, DIRECTOR OF THE CALIFORNIA DEPARTMENT OF HEALTH SERVICES, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR THE PETITIONER

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QUESTIONS PRESENTED

1. Whether language in an internal agency manual prepared for use by field employees is a "legislative regulation" that binds the Secretary of Health and Human Services, even though it was never subjected to notice-and-comment rulemaking or published in the Federal Register, and even though it is contradicted by a regulation duly promulgated by the Secretary pursuant to the Administrative Procedure Act.

2. Whether Section 2373(c) of the Deficit Reduction Act of 1984, Pub. L. No. 98-369, 98 Stat. 1112, prohibits the Secretary from disapproving proposed amendments to state Medicaid plans that conflict with statutory limitations on federal financial participation in the Medicaid program.

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In the Supreme Court of the United States

OCTOBER TERM, 1986

No. 86-863

OTIS R. BOWEN, SECRETARY OF HEALTH AND HUMAN SERVICES, PETITIONER

v.

KENNETH KIZER, DIRECTOR OF THE CALIFORNIA DEPARTMENT OF HEALTH SERVICES, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR THE PETITIONER

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-19a) is reported at 781 F.2d 1421. The opinion dissenting from the denial of rehearing en banc (Pet. App. 23a-35a) is reported at 794 F.2d 540. The opinion of the Administrator of the Health Care Financing Administration (Pet. App. 38a-45a) is unreported. The recommended decision of the hearing officer (J.A. 7-15) is unreported.

JURISDICTION

The judgment of the court of appeals (Pet. App. 21a) was entered on February 7, 1986. An order

amending the panel opinion was entered on March 6, 1986 (Pet. App. 20a). A petition for rehearing was denied on July 14, 1986 (Pet. App. 22a). An opinion dissenting from the denial of rehearing en banc was filed on July 18, 1986 (Pet. App. 23a-35a). On October 3, 1986, Justice O'Connor extended the time within which to file a petition for a writ of certiorari to and including November 26, 1986. The petition was filed on that date, and was granted on February 23, 1987 (J.A. 69). The jurisdiction of this Court rests on 28 U.S.C. 1254(1).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

The relevant portions of Sections 1902(a) and 1903(f) of the Social Security Act, 42 U.S.C. (& Supp. III) 1396a(a) and 1396b(f), of Section 2373 (c) of the Deficit Reduction Act of 1984, Pub. L. No. 98-369, 98 Stat. 1112, of 42 C.F.R. 435.811 and 435.1007, and of Section 14005.12 of the California Welfare and Institutions Code (West Supp. 1987), are set out at Pet. App. 46a-49a.

STATEMENT

This case involves an effort by the State of California to afford a particular category of Medicaid recipients—medically needy adult couples—a level of Medicaid benefits that exceeds the statutory cap on federal financial participation. As a rule, of course, a state may be as generous or as parsimonious as it wishes with its own funds. In Section 1903(f) of the Social Security Act, however, Congress has established a ceiling on the income levels of individuals toward whose Medicaid benefits the federal government will contribute. Because it was clear that Cali-

fornia's proposed amendment to its state plan would increase Medicaid benefit levels to an amount in excess of this statutory cap, and because the state sought federal participation in financing that increase, the Secretary rejected California's proposal.

The court of appeals reversed. In holding that the Secretary was bound to approve California's proposed amendment, the court ignored a regulation duly promulgated by the Secretary that tracks the language of the statutory cap on federal financial participation. The court relied instead on a statement that had appeared some years earlier in an unpublished internal agency manual. It did not matter to the court that the Secretary had never endorsed the interpretation set forth in the manual, that the manual contradicted the Secretary's previously published regulation, that the manual satisfied none of the notice and publication requirements that regulations ordinarily must meet, that the statement in the manual was deleted from subsequent versions of the manual, or that the Secretary had declared the manual provision to be void ab initio. The court held that the manual was nevertheless a "proper legislative rule" that binds the Secretary (Pet. App. 13a). The court also held that the Secretary had no authority to enforce the income eligibility ceiling set forth as a condition of federal financial participation in Section 1903(f). For that conclusion the court relied on a provision in the Deficit Reduction Act of 1984 that by its terms has no bearing whatever on Section 1903(f).

A. The Medicaid Program

1. Congress established the Medicaid program in 1965 "for the purpose of providing federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons." *Har-*

ris v. *McRae*, 448 U.S. 297, 301 (1980); see *Atkins* v. *Rivera*, No. 85-632 (June 23, 1986), slip op. 2. Medicaid is a cooperative federal-state program employing both state and federal funds. See 42 U.S.C. (& Supp. III) 1396b. The decision whether to participate in Medicaid is left to the discretion of each state. Once a state elects to participate, it must comply with requirements imposed by the Medicaid Act and by the Secretary of Health and Human Services. See 42 U.S.C. (& Supp. III) 1396a; *Atkins* v. *Rivera*, slip op. 2; *Schweiker* v. *Gray Panthers*, 453 U.S. 34, 37 (1981). Upon obtaining the Secretary's approval of its Medicaid plan, a state is entitled to federal financial assistance for providing medical care to individuals who qualify under that plan. See 42 U.S.C. (& Supp. III) 1316(a), 1396, 1396a(b), 1396b(a).

Individuals covered by certain cash assistance programs—the Supplemental Security Income (SSI) Program, 42 U.S.C. (& Supp. III) 1381 *et seq.*, and the Aid to Families with Dependent Children (AFDC) Program, 42 U.S.C. (& Supp. III) 602 *et seq.*—automatically qualify for Medicaid. Thus, states that choose to participate in Medicaid must provide Medicaid benefits to these persons, termed the "categorically needy." See 42 U.S.C. (Supp. III) 1396a(a)(10)(A)(i); 42 C.F.R. 435.4, 433.110(a), 435.120(a); *Atkins* v. *Rivera*, slip op. 2; *Gray Panthers*, 453 U.S. at 37-39. In addition, and at its option, a participating state may provide Medicaid benefits to other "less needy" individuals. See H.R. Rep. 213, 89th Cong., 1st Sess. 66 (1965). In general, these are individuals whose income or resources somewhat exceed the eligibility levels for the SSI and AFDC programs, but who incur substantial medical expenses. These individuals are generally termed the

"medically needy." See *Atkins* v. *Rivera*, slip op. 3; *Schweiker* v. *Hogan*, 457 U.S. 569, 572-573 (1982). The "medically needy" qualify for Medicaid only if they incur medical expenses that reduce their income to the Medicaid eligibility income standard or if their income is below that standard. See 42 U.S.C. 1396a (a)(10)(C) and 1396a(a)(17); 42 C.F.R. 435.831 (c).

2. At the beginning of the Medicaid program, federal reimbursement was available to a state that elected to provide optional coverage to the "medically needy" regardless of how high the state chose to set its Medicaid eligibility income standard. In 1967, however, Congress determined that a limit on federal financial participation was desirable to guard against improvident Medicaid spending by the states. See *Schweiker* v. *Hogan*, 457 U.S. at 573, 576. Accordingly, Congress passed legislation to ensure that "[f]ederal sharing * * * not be available for families whose income exceeds 133⅓ percent of the highest amount ordinarily paid to a family of the same size * * * in the form of money payments under the AFDC program." H.R. Rep. 544, 90th Cong., 1st Sess. 117, 119 (1967).[1] To effect that purpose, Congress enacted Section 1903(f)(1)(B)(i) of the Social Security Act, 42 U.S.C. 1396b(f)(1)(B)(i). That Section provides that federal financial participation is available only to the extent that the state limits its Medicaid eligibility income standard as follows:

> * * * the applicable income limitation with respect to any family is the amount determined, in

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[1] Typically, income levels for AFDC eligibility are the lowest among the categorical assistance programs. H.R. Rep. 544, *supra*, at 117, 119; see *Schweiker* v. *Hogan*, 457 U.S. at 577.

> accordance with standards prescribed by the Secretary, to be equivalent to 133⅓ percent of the highest amount which would ordinarily be paid to a family of the same size without any income or resources, in the form of money payments, under the [AFDC] plan of [that] State * * *.

The Secretary issued regulations in 1971 pursuant to this directive. 36 Fed. Reg. 3871-3872. Those regulations, now codified at 42 C.F.R. 435.1007, reiterate the statutory requirement that a state's Medicaid eligibility income level must bear a fixed mathematical relationship to its AFDC eligibility income level for "a family of the same size." The regulations provide that, for couples and families of two or more, federal financial participation is available only when the state's Medicaid eligibility income level does not exceed "133⅓ percent of the highest money payment that would ordinarily be made under the State's AFDC plan to a family of the same size without income and resources." 42 C.F.R. 435.1007(a)(1). See also 42 C.F.R. 435.811(c).[2]

B. Proceedings in this Case

1. Respondent Kizer is the Director of the California Department of Health Services; the other respondents are Medicaid recipients who intervened

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[2] The regulations promulgated in 1971 were initially codified at 45 C.F.R. 248.21(b)(2) and (3) (1972). They were recodified in 1974 at 45 C.F.R. 248.4(b)(4) (1974), and again in 1978 at 42 C.F.R. 448.4(b)(4) (1977). In September 1978, the regulations were amended to their present form and recodified at 42 C.F.R. 435.1007. The language at issue in this case ("family of the same size") has not undergone substantive change since the initial regulations were issued in 1971.

below. From 1976 to 1982, California had allowed a so-called "special income deduction" to medically needy adult couples (J.A. 58; see C.A. App. 80, 111, 275). The effect of this deduction was to set California's "medically needy income level," or "MNIL," for adult couples at a point above the ceiling established in Section 1903(f) as a condition of federal reimbursement. For that reason, the Secretary had disapproved California's pre-1982 eligibility levels (see C.A. App. 127, 275).

In June 1982, the California legislature amended the statute underlying the State's Medicaid plan by repealing the "special income deduction" (J.A. 58). The effect of this repeal was to revise downward the state's MNIL for medically needy adult couples and bring it into conformity with the ceiling set forth in Section 1903(f).[3] Consistently with Section 1903(f) and 42 C.F.R. 435.1007(a)(1), therefore, the State's 1982 amendment computed MNILs for all medically needy families, including medically needy adult

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[3] The effects of a reduction in the MNIL may be illustrated by a simplified example. Assume a "medically needy" family with monthly countable income of $300 and monthly medical expenses of $150. If the state's MNIL is $250, that family must pay the first $50 of its medical expenses, bringing its monthly income down to the Medicaid eligibility standard; at that point, the family may retain the remaining $250 of its monthly income for nonmedical needs and Medicaid will pay the other $100 of its medical costs. Now assume that the state lowers its MNIL to $200. That same family would then keep only $200 for nonmedical needs; Medicaid would cover only $50 of its medical bills, and the family would be responsible for the remaining $100 of its monthly medical expenses. As this illustration shows, the lower the MNIL, the smaller the proportion of medical expenses covered by Medicaid. Program costs further decrease with a lower MNIL because fewer people qualify for benefits.

couples, as 133⅓% of the maximum AFDC grant for a family of the same size. That formula produced an MNIL of $544 for a family of two (J.A. 58).

One year later, the California legislature perceived (see J.A. 60) what this Court had recognized in 1982, and what Congress had recognized in 1967 when it enacted the cap on federal financial participation: that because Medicaid eligibility income levels are linked to those for AFDC, which are typically "the lowest that are used in the categorical assistance programs" (H.R. Rep. 544, *supra*, at 119), the medically needy may end up with less income after paying their share of medical expenses than will some of the categorically needy. See *Schweiker* v. *Hogan*, 457 U.S. at 583, 584-588, 589-593 (rejecting statutory and constitutional challenges based on that fact). Thus, as a consequence of California's lowering of its Medicaid MNIL in 1982, the State's "[m]edically needy aged and disabled people experienced a very sharp increase in the share of [medical expenses] which they were required to meet each month in order to qualify" for Medicaid (J.A. 58-59).

In 1983, "under considerable pressure from recipient groups" (C.A. App. 127; see generally *id.* at 611-822; J.A. 60), the California legislature set about undoing the effects of the 1982 amendment. What California sought to do, in essence, was to increase Medicaid benefits for elderly couples, without making a correlative increase in AFDC benefits for families consisting of a parent and a child. Thus, while adjusting AFDC grant levels only slightly, California proposed a far more generous increase in benefits for two-person Medicaid families comprised exclusively of adults by raising the Medicaid MNIL for that class of recipients. The State sought to ac-

complish this revision by providing that the monthly MNIL for a family consisting of two adults would now be 133⅓% of "the highest amount that would ordinarily be paid to a family of *three* persons without income or resources under [the State's AFDC program]." Cal. Welf. & Inst. Code § 14005.12(c) (West Supp. 1987) (emphasis added). Since AFDC benefit levels were of course higher for a family of three than for a family of two, California's proposal would have had the effect of raising Medicaid benefits for elderly couples without necessitating a correlative increase in AFDC spending.

California's proposed 1983 amendment would thus have produced two significant changes in the State's Medicaid plan. First, it would have provided a different MNIL for a family of two adults than for a family of two comprising one adult and one child. Second, for a two-adult family, the statute would have established an MNIL with reference to an AFDC family of three rather than an AFDC family of two. In financial terms, the result would have been to leave the MNIL for a two-person family comprised of one adult and one child at $567 (133⅓% of the slightly higher 1983 AFDC grant for a family of two), while raising the MNIL for a two-person family comprised of two adults to $709, or $142 in excess of the maximum level permitted by Section 1903(f). See J.A. 24. The California legislature also provided specific instructions that the state agency was to follow in the event that the 1983 amendment was found to violate federal law.[4]

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[4] Section 124.7 of 1983 Cal. Stat. provided in part (C.A. App. 144-145):

> (a) * * * No provision of Section * * * 14005.12 of the Welfare and Institutions Code shall be considered to be in conflict with any federal statute or regulation until

2. Following enactment of California's 1983 legislation,[5] respondent Kizer's predecessor wrote to the Administrator of the Health Care Financing Admin-

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after a final determination of the Secretary of the United States Department of Health and Human Services * * *.

(b) In the event of an initial determination by the Secretary of the United States Department of Health and Human Services that any provision of this act is in conflict with any federal statute or regulation, the State Department of Health Services shall take all available and necessary steps to obtain a final determination reversing that decision. In the event of a final determination finding a conflict with federal law, the State Department of Health Services shall immediately request the State Attorney General to seek judicial review of the determination, and shall immediately notify the appropriate policy and fiscal committees of both houses of the Legislature.

(c) In the event of a final determination finding that any provision of this act conflicts with federal law, the State Department of Health Services shall adopt emergency regulations * * * if necessary to avoid withholding of federal reimbursement. The department shall further seek a federal waiver to permit implementation of the provision [found] to be in conflict with federal law, and shall continue to implement all [other] provisions of this act * * *.

[5] Even before the 1983 legislation was passed, it was recognized within the California Department of Health Services that the pending bill conflicted with federal requirements (C.A. App. 135, 327). The state agency had therefore considered several options as against the probability that the proposed amendment would be found to violate federal law. Among the options considered were a delay in implementing the portion of the amendment establishing a higher MNIL for two-adult families, implementing that provision and risking federal sanctions, and implementing the provision without seeking federal financial participation for benefits paid to persons whose income levels exceeded the federal limits (C.A. App. 136-137).

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istration (HCFA), a subdivision of HHS, to request a "formal ruling" about the validity of California's provision setting new, higher Medicaid levels. Respondent stated that "[o]ur staff analysis has concluded that this provision not only exceeds the maximum limitation on Federal Financial Participation specified [in Section 1903(f)], but also that this provision is not in conformity with Section 1902(a)(10)(C)(i)(III) of the Social Security Act which specifies that the State must apply a single income standard to medically needy families of the same size regardless of family composition" (C.A. App. 140-141).[6] The HCFA Administrator's response, dated

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[6] Section 1902(a)(10)(C)(i)(III) of the Social Security Act, added by the Tax Equity and Financial Responsibility Act of 1982 (TEFRA), Pub. L. No. 97-248, § 137(b)(8), 96 Stat. 378, 42 U.S.C. 1396a(a)(10)(C)(i)(III), requires that a state's Medicaid plan must establish a "single standard" for determining income and resource eligibility of a family of a particular size. This is the provision that later became a subject of the "DEFRA moratorium," the proper interpretation of which is involved in the second question presented by our petition in this case. See pages 41-49, *infra*. As respondent noted in his 1983 letter to the HCFA Administrator, Section 1903(f) and Section 1902(a)(10)(C)(i)(III) represented entirely distinct grounds for invalidating California's 1983 amendment to its Medicaid plan.

A simplified example will show how the 133⅓% cap of Section 1903(f) operates independently of the "single standard" rule of Section 1902(a)(10)(C)(i)(III). Assume a state where the highest monthly AFDC benefit ordinarily paid to a family of two is $300. If that state were to establish a Medicaid eligibility level of $350 for a family consisting of one adult and one child, and a separate level of $400 for a family consisting of two adults, a question could thereby be raised under the TEFRA "single standard" provision. But the 133⅓% cap of Section 1903(f)—viz., 133⅓% of $300, or $400—would not be exceeded in either event. Conversely, if

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September 6, 1983, concurred in respondent's conclusion that the 1983 California amendment, which fixed the two-adult MNIL by reference to the AFDC level for a family of three, violated federal statutory and regulatory requirements. The Administrator accordingly informed respondent that federal financial participation would to that extent not be available (C.A. App. 142-143).

California nonetheless attempted to implement its 1983 amendment, formally transmitting its proposal to amend its Medicaid plan to HCFA on September 20, 1983 (J.A. 22-24). The State's submission indicated that its proposed MNILs complied with Section 1903(f) "except for [the MNIL] for 2 adults," for whom the MNIL was "equal to 133⅓% of [the] AFDC payment level for 3 persons" (J.A. 23). Although the State expressly acknowledged that its proposed MNIL for two-adult families would exceed the federal participation cap by $142 per month (J.A. 24), it sought federal financial participation for the full amount of the proposed benefits to be provided to recipients whose incomes exceeded the federal limits. This was indicated by the State's having crossed out the following language that appears at the bottom of the preprinted transmittal form: "The agency has methods for excluding from its claim for [federal financial participation those] payments [which are] made on behalf of individuals whose income exceeds these limits" (*ibid.*).

3. In December 1983, the HCFA Administrator disapproved California's proposed plan amendment

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that same state were to set its Medicaid eligibility level for all families of two (whether consisting of two adults or of one adult and one child) at $450, there would be no question raised under the "single standard" provision. But the state would be in violation of the 133⅓% cap of Section 1903(f).

because it did not comply with the statutory and regulatory requirement that federal financial participation not be available where a state's Medicaid MNILs exceed 133⅓% of the maximum AFDC payment "to a family of the same size." See Section 1903(f); 42 C.F.R. 435.1007(a); J.A. 25-26. On February 16, 1984, the State requested reconsideration of the Administrator's decision (J.A. 31-33). A hearing was held on July 2, 1984 (J.A. 8).

The hearing officer recommended (J.A. 7-15) that the disapproval of California's proposed plan amendment should be affirmed. The State's main contention was that its proposed amendment was supported by language that appeared in a HCFA regional office manual issued in June 1979. In contrast to the statute and to the regulation promulgated by the Secretary in 1971, which require that a state's Medicaid MNIL be no more than 133⅓% of the state's maximum AFDC payment for a family "of the same size," the field manual said (§ 2572D) that "the States may set a separate * * * [MNIL] for two adults which would be established between 133⅓ percent of the AFDC payment level for one person and 133⅓ percent of the AFDC payment level for a family of three persons" (see J.A. 21). The field manual also said that states "should have the option of establishing separate * * * [MNILs] for a two-person family consisting of one adult and one child and for a two-person family composed of two adults" (*ibid.*).

The hearing officer rejected the State's contention, concluding that the manual provision "is not a regulation, has no legal force and does not bind HCFA" (J.A. 14). He explained that the manual was "intended for internal regional office use, i.e., for the use of regional office employees only," emphasizing

that the manual's foreward "instructs regional office employees not to cite [the manual] to others" (*id.* at 10). The hearing officer accordingly found (*id.* at 11) that HCFA's office manual "if anything, has less, but certainly no more importance than the SSA Claims Manual" that was held not to constitute a binding regulation in *Schweiker* v. *Hansen*, 450 U.S. 785 (1981). At all events, the hearing officer concluded that "Congress [had] specifically rejected [the manual's] interpretation of section 1903(f)." J.A. 14; see *id.* at 12.

The hearing officer also rejected the State's alternative contention that Section 2373(c) of the Deficit Reduction Act of 1984 (DEFRA), Pub. L. No. 98-369, 98 Stat. 1112, prohibited the Secretary from disapproving California's proposed amendment. The hearing officer explained that Section 2373(c) of DEFRA, the so-called "DEFRA moratorium," was "limited to violations of section 1902(a)(10)(C)(i)(III) of the [Social Security] Act." [7] The hearing officer pointed out that California's proposed amendment had been disapproved under Section 1903(f), not under Section 1902(a)(10)(C)(i)(III), and that the DEFRA moratorium "does not touch upon violations of section 1903(f)." J.A. 13.

On further administrative appeal, the HCFA Administrator issued a final decision upholding the hearing officer's recommended determination (Pet. App. 38a-45a). The Administrator observed that Section 1903(f) "provides for a single MNIL for a family of two" and that this limit is 133⅓% of the maximum payment ordinarily made under the State's

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[7] The operation of Section 1902(a)(10)(C)(i)(III) of the Act is described in note 6, *supra*, and is more thoroughly discussed at pages 41-47, *infra*.

AFDC plan "to a family of the same size without income and resources" (Pet. App. 42a). The Administrator further noted that the Secretary's regulation, which likewise speaks of AFDC payments "to a family of the same size" (42 C.F.R. 435.1007), was "absolutely clear regarding a family of two" (Pet. App. 42a). The Administrator found the language in the HCFA field manual to be "patently contrary to the statute and * * * , therefore, invalid from its origination," since "the Secretary is bound to follow the direction of Congress" (*id.* at 44a).[8]

4. On petition for review, a panel of the Ninth Circuit reversed the agency's determination (Pet. App. 1a-19a). The court acknowledged that Section 1903(f) restricted federal financial participation to cases where the state's Medicaid MNIL was no higher than 133⅓% of the highest AFDC payment "to a family of the same size." But the court said that this directive was tempered by other language in Section 1903(f), which required that the federal cap be determined "in accordance with standards prescribed by the Secretary" (Pet. App. 7a, citing 42 U.S.C. 1396b(f)(1)(B)(i) (emphasis omitted)). In the court's view, HCFA's 1979 regional office manual had prescribed just such a "standard," so that California could therefore set its adult-couple MNIL as high as "133⅓ percent of the AFDC payment level for a family of three persons." The court concluded that the manual set forth "a proper legislative rule" because it is a "rule 'issued by an agency pursuant to statutory authority and * * * implements the stat-

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[8] As had the hearing officer, the Administrator also rejected the State's alternative argument based on the DEFRA moratorium (Pet. App. 40a, 41a).

ute' " (Pet. App. 13a, quoting *Batterton* v. *Francis*, 432 U.S. 416, 425 n.9 (1977)).

Citing this Court's decision in *Schweiker* v. *Hansen*, 450 U.S. 785 (1981), the court of appeals acknowledged that "agency office manuals generally do not prescribe legislative rules with binding effect" (Pet. App. 11a). But the court held that this case represented "an exception" to that principle, asserting that the office manual involved here was "not a field-level instructional guide" because it was supposedly "directed not at office-level agency employees and specific recipients but at states and a major category of recipients under state plans" (*ibid.*). The court said that the 1979 version of the HCFA regional manual "establishe[d] the right of states to increase their adult couple MNIL" and "establishe[d] a new MNIL maximum * * * and thereby 'effect[ed] a change in existing law or policy' " (*ibid.*, quoting *Powderly* v. *Schweiker*, 704 F.2d 1092, 1098 (9th Cir. 1983)).

Although the language in the field manual had never been subject to notice-and-comment rulemaking, and although it had not been published in the Federal Register or the Code of Federal Regulations, the court of appeals held that the manual had been properly promulgated as a "legislative regulation." The court noted (Pet. App. 13a) that the notice-and-comment procedures of the Administrative Procedure Act (APA) are generally inapplicable to matters relating to public benefits (5 U.S.C. 553(a)(2)). Although the Secretary by formal notice (36 Fed. Reg. 2532 (1971)) has voluntarily imposed the full panoply of APA procedural requirements upon HHS in such matters, the court stated that, in promulgating the manual, the Secretary had simply "failed to abide

by her predecessor's promise to adopt APA rule-making procedures" (Pet. App. 14a). On that basis, the court concluded that the absence of notice-and-comment proceedings did not deny the manual the force of law (*ibid.*).

With respect to the requirement of the Freedom of Information Act (FOIA) that agency regulations be published in the Federal Register (5 U.S.C. 552(a)(1)(D)), the court concluded that the FOIA requirement attaches only where nonpublication "would adversely affect a member of the public," a situation that the court found was not present here (Pet. App. 15a). The court therefore held that the manual was a lawfully promulgated regulation, exempt from the procedural requirements of the APA and the FOIA. And the Court held as an alternative ground of decision that "the DEFRA moratorium" in any event barred the Secretary from disapproving the proposed amendment to California's Medicaid plan (*id.* at 16a-18a).

5. The Secretary's suggestion for rehearing en banc was denied, with Judges Kozinski, Sneed, Hall and Noonan dissenting (Pet. App. 22a-35a). In the dissenters' view, "[t]he panel err[ed] in almost every respect" (*id.* at 26a). The dissent pointed out that HCFA's regional manual was "not a body of regulations," but rather was "an *office manual*, an internal directive from the agency's headquarters to its field offices" (*ibid.* (emphasis in original)). The manual's "[f]oreward," the dissent observed, stated that it was " 'for the use of regional office employees only,' " that it was " 'not intended to stand alone,' " and that it " 'should not be cited when addressing contractors, State agencies, providers, etc.' " (*id.* at 26a-27a (citation omitted)). Thus, even if

the manual were the only statement on the subject emanating from the government, the dissent concluded that the manual would not, under *Schweiker* v. *Hansen*, *supra*, constitute a "legislative regulation" with the force and effect of law.

The dissent went on to argue that this conclusion followed *a fortiori* here, since the Secretary had in fact promulgated valid regulations that "plainly conflict" with the manual section (Pet. App. 29a). Instead of deferring to these regulations, which explicitly link a family's Medicaid entitlement to that of an AFDC family "of the same size," the panel "effectively read[] the regulations out of existence without any explanation or admission of the fact" (*id.* at 30a). By subordinating formally promulgated regulations to an internal agency publication, the panel opinion, in the dissent's view, "tears asunder [the] tenets of administrative law" (*id.* at 31a) and "create[s] uncertainty where stability is vital" (*id.* at 32a). Judge Kozinski expressed concern that the panel opinion "will cause no end of headaches for agency officials who will now have to guess which of their informal, unsigned, internal guidelines will be found 'exceptional' enough to outrank regulations" (*ibid.*). And he pointed out that, even if the manual could be thought to be a "regulation," it would be invalid "because it violates the plain language of the statute" (*id.* at 30a).

The dissent also took issue with the panel's alternative holding based on the DEFRA moratorium. Relying in part on this Court's decision in *Atkins* v. *Rivera*, *supra*, the dissent pointed out that the DEFRA moratorium "has nothing at all to do with this case" since it was intended to restrict the Secretary's authority under a portion of the statute not involved

here (Pet. App. 34a). In Judge Kozinski's words (*ibid.*), "[t]he two provisions have about as much in common as apples and pineapples: They sound vaguely similar but they grow on entirely different statutory trees."

SUMMARY OF ARGUMENT

The court of appeals has raised the curtain on a revolution in administrative law. The court's principal holding is that a statement in an unofficial, unpublished, obsolete, internal agency manual can rise to the status of a "legislative regulation" that binds the agency, even though the statement is contrary to the plain language of the relevant statute and to the agency's own, duly promulgated rules. That holding does violence to settled principles of administrative law, thwarts specific congressional intent, and substantially undermines federal fiscal control over the Medicaid program.

1. In setting the statutory cap on federal financial participation in the Medicaid program, Congress spoke clearly and directly. A state is entitled to federal participation in Medicaid if the state's Medicaid eligibility level for a family of a given size does not exceed 133⅓% of the highest amount ordinarily payable in monthly AFDC benefits "to a family of the same size" (42 U.S.C. 1396b(f)(1)(B)(i)). There is no mystery to this language; no enigma that can be deciphered only by Medicaid cognoscenti. California's proposed amendment failed to qualify under this statute because a family of three is not the "same size" as a family of two.

Although the clarity of the statutory language makes resort to its legislative history unnecessary,

we note that the legislative history fully supports our view. In adopting the House version of Section 1903 (f) in preference to the more expansive limit proposed by the Senate, Congress evidenced its intent to keep on a relatively short tether those states that chose to provide federally-supported assistance to the medically needy. Nothing in the legislative history supports the construction of the statute that the court of appeals has advanced.

Even if the statutory language or the legislative history left room for uncertainty, it would be eliminated by the consistent official interpretation of the agency charged with administering the statute. Duly promulgated regulations issued by the Secretary have, since 1971, incorporated verbatim the statutory "same size" requirement; these regulations fit comfortably within the category of regulations that are entitled to "legislative effect" (*Atkins* v. *Rivera*, slip op. 7). At all events, the Secretary has never interpreted the statute as conferring the authority discovered by the court of appeals: the authority to decree that a family of two is the "same size" as a family of three.

The court of appeals, brushing aside the agency's officially published rules, chose instead to treat as a "legislative regulation" a statement contained in a regional office manual in 1979. That statement, which was contrary to the plain language of the statute, which was never endorsed by the Secretary, which was never published in the Federal Register or the Code of Federal Regulations, which was deleted shortly after it first appeared in the manual, and which was rejected in the administrative proceedings in this case as a nullity, is not a "regulation" at all, much less a "legislative regulation." Indeed, even if

the manual provision had been the only relevant pronouncement emanating from the agency, it would still have to be rejected as contrary to Congress's stated intent.

Unless reversed, the decison below will undermine Congress's longstanding requirement that the cap on federal financial participation in Medicaid be set according to the "family of the same size" standard. More generally, the decision below would seriously disrupt the orderliness and regularity of the administrative process. If rules duly promulgated by the Secretary can be subordinated, as the court of appeals held, to informal, internal communications by lower-level employees, then all government officials—and those subject to regulation—will be left to guess which statutes and regulations will be similarly supplanted by ill-considered and anonymous memoranda.

2. The court of appeals also erred in concluding that the DEFRA moratorium precludes the Secretary from enforcing the statutory cap on federal financial participation contained in Section 1903(f). On its face, the DEFRA moratorium is expressly confined to the Secretary's authority under a different section of the statute, and the moratorium makes no mention of Section 1903(f), the section on which the Secretary based his action here. The legislative history of the DEFRA moratorium confirms that Congress had no intention to prevent the Secretary from enforcing the cap on federal financial participation; indeed, Congress specifically rejected a provision that would have accomplished the very result that respondents urge. There is, ultimately, no conceivable reason why DEFRA, a deficit reduction measure, should be interpreted in a way that divests the Sec-

retary of authority to enforce the statutory limit on the federal government's fiscal participation in Medicaid.

ARGUMENT

I. THE SECRETARY CORRECTLY DISAPPROVED CALIFORNIA'S PROPOSED AMENDMENT BECAUSE IT FAILED TO LINK A FAMILY'S MEDICAID ELIGIBILITY LEVEL TO THE AFDC ELIGIBILITY LEVEL OF A FAMILY OF THE SAME SIZE

A. Section 1903(f) And Its Implementing Regulation Expressly Condition Federal Financial Participation On A State's Establishment Of A Medicaid Eligibility Level That Is No Higher Than 133⅓% Of The State's Highest AFDC Payment For "A Family Of The Same Size"

1. This Court has often observed " 'that the legislative purpose is expressed by the ordinary meaning of the words used.' " *United States* v. *James*, No. 85-434 (July 2, 1986), slip op. 6. There can be no serious doubt that the ordinary meaning of the words used in the Social Security Act appears to settle the question presented here. Section 1903(f) of the Act provides that, for Medicaid purposes, "the applicable income limitation with respect to any family" is "133⅓ percent of the highest amount which would ordinarily be paid to a family of the same size without any income or resources, * * * under the [AFDC] plan of the State" (42 U.S.C. 1396b(f)(1)(B)(i)). California proposed, by contrast, to compute its Medicaid income limitation for certain families of two as 133⅓% of the highest AFDC benefits ordinarily payable to a family of three. Under normal English usage, a family of three and a family of two would not be regarded as being "the same size." The plain

language of the statute thus makes clear that California cannot claim federal reimbursement for the added Medicaid costs occasioned by its 1983 plan amendment.

Because the statutory language is unambiguous, there is no need in this case to "turn to the legislative history as an additional tool of analysis" (*Garcia* v. *United States*, 469 U.S. 70, 75 (1984); see *United States* v. *Rojas-Contreras*, No. 84-1023 (Dec. 16, 1985), slip op. 4). But examination of that legislative history lends no support whatever to respondents' contentions. Rather, it adds compelling support to our view that Congress never intended to authorize the Secretary to compute Medicaid eligibility in the manner California wishes. Cf. *INS* v. *Cardoza-Fonseca*, No. 85-782 (Mar. 9, 1987), slip op. 10-11 n.12.

At the inception of the Medicaid program, Congress left it to the states to establish Medicaid eligibility and benefit levels, and hence placed no limit on the amount of federal reimbursement that a state could claim for providing optional benefits to the "medically needy." "Within a year," however, "Congress recognized that it was fiscally improvident to rely exclusively on the States to set income limits" (*Schweiker* v. *Hogan*, 457 U.S. at 575). In 1967, therefore, Congress established a limit on federal financial participation. After extensive hearings, the House reported a bill that proposed to limit federal financial participation to "133⅓ percent of the highest amount ordinarily paid to a family of the same size (without any income and resources) in the form of money payments under the AFDC program." H.R. Rep. 544, *supra*, at 119. The House Report specifically noted that "AFDC income limits are, generally

speaking, the lowest that are used in the categorical assistance programs." *Ibid.*

The Senate acknowledged that the House bill had the objective of "substantially limiting Federal financial participation in the medicaid program." S. Rep. 744, 90th Cong., 1st Sess. 176 (1967). But while it agreed that some restriction on federal financial participation was needed, the Senate devised "an alternative way of accomplishing the basic purpose of the House bill" (*ibid.*). The Senate alternative was to cap federal financial participation by limiting Medicaid eligibility to 150% of the state's Old Age Assistance (OAA) level. Because the OAA program was typically the most generous of the federal cash assistance programs, the Senate alternative would have permitted states to obtain federal funding for much higher Medicaid benefits than under the House bill. S. Rep. 744, *supra*, at 177.

The Senate alternative was rejected in conference. See *Schweiker* v. *Hogan*, 457 U.S. at 579-580 n.15; H.R. Conf. Rep. 1030, 90th Cong., 1st Sess. 63 (1967). Senator Robert Kennedy observed that "[t]he Senate conceded, in conference, almost every provision where its approach was more liberal than that of the House * * *." 113 Cong. Rec. 36783 (1967). Senator Mondale explained the House provision, which he had opposed, as follows (*id.* at 37819):

> The House bill limits Federal participation in title 19 programs to those whose income is less than 133 percent of the highest amount ordinarily paid families of similar size under the State aid-to-dependent-children programs.

It was this provision of the House bill, firmly linking a family's Medicaid eligibility to the AFDC eligibility

of a family of the "same size," that was enacted into law. No mention was made of giving the Secretary authority to alter that legislative determination in any respect.[9]

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[9] In view of the legislative history of Section 1903(f), the concerns that prompted California to propose its 1983 plan amendment, no less than the literal terms of that amendment, are at odds with congressional intent. California's proposal was animated by the perception that some "medically needy" persons, after paying their share of medical expenses, could end up with less income than some "categorically needy" persons, such as SSI recipients. See J.A. 58. But Congress plainly recognized that this could happen and intended that result, since it deliberately chose to link Medicaid eligibility to income levels under the least generous (AFDC), rather than under the most generous (OAA), categorical assistance program.

The fact that Congress chose to limit federal financial participation in this way, of course, does not preclude a state from establishing more generous Medicaid benefits payable out of the state's own funds. Indeed, the printed form on which proposed state plan amendments are transmitted to HCFA (see J.A. 24) specifically contemplates that a state desiring to exceed federal limits will confirm that it has established methods for excluding from its claim for federal financial participation those payments made to individuals whose income exceeds federal limits. A state that so confirms will continue to receive the federal share of Medicaid payments made to individuals whose incomes do not exceed the federal limits. In other areas, California has decided to pay benefits exclusively from state funds, *e.g.*, Cal. Welf. & Inst. Code § 14005.4 (West Supp. 1987) (medically indigent program). But, as we have noted (see pages 11-12, *supra*; J.A. 24), California did not pursue that course here; it opted instead to exceed the federal limits *and* to seek federal participation. See C.A. App. 272-274, 570, 572, 573, 590-592, 598, 600, 835-837.

Another option available to a state seeking to provide more generous Medicaid benefits to adult couples without exceeding federal limits is simply to increase the amount of its AFDC payments to a family of two. Since the Medicaid 133⅓%

2. If the statutory language left any doubt about Congress's intent to peg the "medically needy" eligibility standard for Medicaid benefits to the state's AFDC level for a family of the "same size," that doubt would be resolved by the Secretary's lawfully promulgated regulation. Consistently with the language of the statute, the Secretary has prescribed by regulation that federal financial participation is available only when the state's MNIL does not exceed, for couples and families of two or more, "133⅓ percent of the highest money payment that would ordinarily be made under the State's AFDC plan to a family of the same size without income and resources" (42 C.F.R. 435.1007(a)(1)). The Secretary has administered the Medicaid program in this fashion, pursuant to this regulation and its predecessors, for more than 16 years. See 43 Fed. Reg. 45217 (1978); 36 Fed. Reg. 3871-3872 (1971); see note 2, *supra*. Regulations of this type are entitled to "legislative effect," as this Court recently explained (*Atkins* v. *Rivera*, slip op. 7 (citations omitted)):

> Because the Secretary's regulation appears supported by the plain language of the statute and is adopted pursuant to the explicit grant of rulemaking authority * * *, it is " 'entitled to more than mere deference or weight.' " * * * Indeed,

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cap is keyed to the AFDC level, an increase in the latter necessarily increases the former. Once again, however, California did not pursue that course; it left the AFDC level substantially unchanged while attempting to raise the Medicaid level above the 133⅓% cap. Thus, the issue in this case is not whether California may provide additional assistance for the medical needs of adult couples, but rather whether California may enlist in that effort federal financial participation in excess of the limits set by Congress.

> it is entitled to "legislative effect," * * * and is controlling "unless [it] is arbitrary, capricious, or manifestly contrary to the statute[.]"

3. Although the court of appeals quoted the Secretary's regulation (Pet. App. 6a), it proceeded at once to ignore it. The panel did not find the regulation unclear or ambiguous, nor did it explain how the regulation could be read to permit the result California wanted. Rather, the court purported to find ambiguity in the statute itself. It theorized (Pet. App. 7a, 14a) that the express statutory cap in Section 1903(f) was qualified by other statutory language, language that delegated authority to the Secretary to prescribe standards for determining the amount that is "equivalent to 133⅓ percent of the highest amount which would ordinarily be paid" to an AFDC family of the same size. In essence, the court held that this latter language granted the Secretary discretion to determine that a family of three is the "same size" as a family of two, and that the Secretary had in fact prescribed such a standard.

This reasoning suffers from a variety of defects. To begin with, if the court wished to consult the Secretary's "standard" for performing the mathematical exercise set forth in the statute, the court was obligated to look to the regulation, described above, which the Secretary had promulgated. See 42 C.F.R. 435.1007. As we have explained, that regulation contains no suggestion that a family of three could be deemed to be the "same size" as a family of two. Thus, if the statute were thought ambiguous or incomplete in the absence of "standards prescribed by the Secretary," that ambiguity, as Judge Kozinski

said, "is neatly excised by these regulations" (Pet. App. 30a).

Moreover, even if the Secretary had never promulgated a regulation, it is obvious that Section 1903(f) would not authorize him to prescribe a standard under which a family of two and a family of three would be judged to be "the same size." Rather, the "standards" that the Secretary was authorized to prescribe are those for determining which of a state's AFDC payment levels for a family of a given size is the "highest" that would "ordinarily be paid" to a family of that size. For example, because a state's AFDC program may allow additional benefits to be paid for "special needs" (see 45 C.F.R. 233.20(a)(2)(v)),[10] a state may sometimes pay different amounts to families of a given size depending upon the recognized special needs of family members. There are also certain situations, specified by statute, in which a MNIL must be determined for a medically needy family for which the state's AFDC plan may have no counterpart—*e.g.*, a family of one or a very large family. See 42 U.S.C. 1396b(f)(3), 1396b(f)(1)(B)(ii). It is in these situations that the Secretary was meant to prescribe standards for determining the "highest amount which would ordinarily be paid" to an AFDC family of the same

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[10] "Special needs" payments may cover such circumstances as special nutritional needs or diets, utilities, transportation, education, day care, pregnancy-related needs, clothing, and catastrophic events. Thirty states, the District of Columbia, and Guam have chosen to make AFDC "special needs" payments. See generally Office of Family Assistance, Social Security Administration, U.S. Dep't of Health & Human Services, *Characteristics of State Plans for Aid To Families With Dependent Children Under the Social Security Act Title IV-A* (1986).

size. Once those standards have been employed, one can then multiply that "highest amount" by 133⅓% to derive the maximum MNIL the State may establish for a Medicaid family of that size.

Congress plainly did not delegate to the Secretary the authority to determine that a family of three is the same size as a family of two. To conclude, as did the court of appeals, that the Secretary may prescribe standards that treat two as equal to three is to nullify the statutory requirement of equivalence. "Read in this fashion," Judge Kozinski aptly stated in his dissent, "the statute provides no limits whatsoever on the Secretary's discretion and might as well say 'the Secretary may set the MNIL any way he pleases' " (Pet. App. 31a). In any event, the Secretary has never sought to utilize the discretion, attributed to him by the court of appeals, to pronounce that two equals three.

B. The Court Of Appeals Erred When It Elevated A Provision In An Agency Field Manual Over The Language Of The Statute And The Secretary's Regulation

Even if the Secretary were thought to have discretion to prescribe standards under which a family of two would be deemed to be "the same size" as a family of three, the court of appeals plainly erred in concluding that the Secretary had in fact prescribed such a "standard" in the guise of HCFA's regional office manual. The court ruled that language contained in the 1979 version of the manual—language that was never published in the Federal Register or subjected to normal rulemaking procedures, and which was in conflict with the statutory mandate—was a "legislative rule" that "establish[ed] the right

of states to increase their adult couple MNIL" (Pet. App. 11a). That ruling cannot be reconciled with established principles of administrative law.

1. It is well settled that "not all agency publications are of binding force" (*Lyng* v. *Payne*, No. 84-1948 (June 17, 1986), slip op. 11). Indeed, if agencies were bound by every pronouncement made on their behalf, there would be little reason for Congress to have codified notice-and-comment procedures in the Administrative Procedure Act. Agency manuals, in particular, are a species of agency pronouncement that lack the force and effect of law. *Schweiker* v. *Hansen*, 450 U.S. at 789; *United States* v. *Caceres*, 440 U.S. 741 (1979); *American Farm Lines* v. *Black Ball Freight Service*, 397 U.S. 532 (1970); *Sullivan* v. *United States*, 348 U.S. 170, 172-174 (1954).

In *Schweiker* v. *Hansen*, *supra*, a Social Security claims representative incorrectly told a claimant that she did not qualify for statutory insurance benefits. He also failed to advise her that she should file a written application for benefits, although the Social Security Claims Manual instructed claims representatives to give such advice. In refusing to estop the government from enforcing a lawful condition on the receipt of benefits, this Court acknowledged that the claims representative failed to follow the procedures specified by the Claims Manual. The Court held, however, that "the Claims Manual is not a regulation. It has no legal force, and it does not bind the SSA." 450 U.S. at 789. The Claims Manual, rather than being a compilation of binding regulations, was considered to be only a "handbook for internal use by thousands of SSA employees * * *." *Ibid.*[11]

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[11] In the administrative proceedings in this case, the hearing officer observed that the regional manual on which the court

The court of appeals acknowledged that "agency office manuals generally do not prescribe legislative rules with binding effect," but said that the manual provision at issue here, for two reasons, constituted "an exception" (Pet. App. 11a). First, the court asserted that this provision "establishes a new MNIL maximum in [the adult-couple] category and thereby 'effect[s] a change in existing law or policy' " (*ibid.*, quoting *Powderly* v. *Schweiker*, 704 F.2d 1092, 1098 (9th Cir. 1983)). As Judge Kozinski pointed out, however, the panel's reasoning in this respect "merely assumes the conclusion. A provision can effect a change in existing law or policy only if it has the force of law; if it does not, it cannot" (Pet. App. 28a). Under the panel's reasoning, moreover, an *incorrect* manual provision would almost always be deemed a "legislative rule with binding effect," since an incorrect manual provision would typically "effect a change in existing law or policy." Conversely, a manual provision that conformed to existing law would not have "binding effect" because it would correctly state the law rather than change it. This would be quite an odd result.

The second reason advanced by the panel to justify treating the manual provision as a "legislative rule" was that the manual was assertedly not directed to office-level agency employees, but instead to "states and a major category of recipients under state plans" (Pet. App. 11a). But, as Judge Kozinski explained, the panel's rationale "flies in the face of [the manual's] own description of itself," for the manual ex-

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of appeals relied "if anything, has less" authoritative force than the Claims Manual that this Court ruled in *Hansen* was not a binding regulation (J.A. 11).

plicitly says that it " 'is for the use of regional office employees only and should not be cited when addressing contractors, State agencies, providers, etc.' " (*id.* at 28a (emphasis and citation omitted)). Plainly, the manual was not intended for use by anyone other than HCFA employees. See *Schweiker* v. *Hansen*, *supra*.

The court of appeals failed to acknowledge both the expressly limited purposes of *this* manual, and the limited purposes of agency manuals in general. Moreover, the court failed to explain how the manual, despite its explicit disclaimer, could be regarded as "a legislative rule issued pursuant to statutory authority" (Pet. App. 16a). Even respondents did not contend below that the manual constituted a "legislative rule," and in this court they expressly disavow any reliance on the court of appeals' characterization (see Br. in Opp. 17 n.6).[12]

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[12] Respondents suggest that the court of appeals' characterization of the manual as a "legislative rule" was superfluous, and that the court "could well have rested its judgment upon the ordinary deference which this Court and the court of appeals have given similar regulatory material" (Br. in Opp. 19). This suggestion is without merit because characterization of the manual as a "legislative rule" was essential to the court of appeals' reasoning. The court distinguished *Schweiker* v. *Hansen* and similar cases on the ground that, "[u]nlike the statutes interpreted by the agency manuals in [those] cases * * *, Section 1903(f) expressly authorized the Secretary to prescribe 'standards' " (Pet. App. 13a). The court reasoned that the instant manual was such a "standard," and that, because it was supposedly issued pursuant to an explicit statutory directive, it was a "proper legislative rule" and hence to be distinguished from the agency manuals involved in previous cases. In any event, contrary to respondents' statement, a manual provision that contradicts the express language of the statute and of duly promulgated regu-

2. A principal factor showing that the manual provision does not have the force and effect of law is that it was not issued pursuant to statutory rulemaking authority of the Secretary. "[T]o have [lawful] 'force and effect,'" this Court has stated, a regulation must be " 'issued by an agency pursuant to statutory authority.' " *Chrysler Corp* v. *Brown*, 441 U.S. 281, 301-302 (1979) (citation omitted). As Judge Kozinski correctly observed (Pet. App. 29a), Congress has granted authority to promulgate rules and regulations implementing the Medicaid program to "the Secretary alone" (see 42 U.S.C. (Supp. III) 1302). The Secretary, moreover, has never delegated the authority to promulgate regulations to the Administrator of HCFA, much less to any subordinate HCFA employee. See 42 Fed. Reg. 57352 (1977); 44 Fed. Reg. 31045 (1979). "Like thousands of other internal guidelines issued every year by scores of federal agencies," Judge Kozinski explained, the manual provision at issue here was "issued anonymously; the Foreword alone is signed and that by the Director of the Bureau of Health Insurance, an official far subordinate to the Secretary" (Pet. App. 29a). "Guidelines issued by someone without authority to promulgate regulations are simply not regulations" (*ibid.*). See *General Electric Co.* v. *Gilbert*, 429 U.S. 125, 141 (1976).

Agency discretion to promulgate rules is also circumscribed by the "procedural requirements imposed by Congress." *Chrysler Corp.* v. *Brown*, 441 U.S. at 303. Both the Administrative Procedure Act and the Freedom of Information Act require that a rule be

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lations, and that suffers from the other deficiencies we have described, is not "regulatory material" to which any "deference" is due.

published before it can be deemed to have *any* force and effect. The manual provision was never published in either the Federal Register or the Code of Federal Regulations.[13] The United States Court of Appeals for the District of Columbia Circuit, speaking through Judge (now Justice) Scalia, recently observed: "The real dividing point between regulations [and other agency pronouncements] is publication in the Code of Federal Regulations, which the statute authorizes to contain only documents 'having general applicability and *legal effect.*'" *Brock* v. *Cathedral Bluffs Shale Oil Co.*, 796 F.2d 533, 539 (1986) (quoting 44 U.S.C. 1510(a) (emphasis in original)). A statement in an agency field manual that does not spring from the Secretary's statutory rulemaking power, that was not the subject of notice-and-comment rulemaking, and that was never officially published cannot "bind" the Secretary.

3. Finally, even if the manual provision could be deemed a procedurally-sound substantive rule issued under a proper grant of statutory authority, the manual provision would still be invalid because it obviously conflicts with the language of the Social Security Act. The Act prescribes a strict formula for the calculation of the cap on federal financial participation: a state's Medicaid MNIL for a family of a given size can be no higher than 133⅓% of the

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[13] Respondents describe the regional office manual (Br. in Opp. 4) as a document "published by HHS' Health Care Financing Administration." Respondents also refer to the manual as a "published interpretation[]," by which they mean that "it was published in the CCH Medicare & Medicaid Guide" (Br. in Opp. 21). This sort of "publication," of course, is irrelevant in determining whether printed matter is an agency "regulation."

state's maximum AFDC payment to a family of the same size. In sharp contrast, the manual suggests (§ 2572D) that the states may set a standard for two adults "between 133⅓ percent of the AFDC payment level for one person and 133⅓ percent of the AFDC payment level for a family of three persons" (J.A. 21). In light of the statutory language, the manual provision was, as the HCFA Adminstrator held, a nullity (Pet. App. 44a). The Secretary's long-standing regulation mandates the same conclusion. That regulation has been in effect since 1971 and has never been repealed, unless the court of appeals means to say that the manual provision "repealed" the regulation. Administrative regularity dictates that as between a duly promulgated, officially published regulation and an agency field manual, it is the former, not the latter, that is binding.[14]

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[14] Although one can only speculate about the genesis of the erroneous manual provision, the error may have stemmed from an incorrect extrapolation from Medicaid rules governing families of one person. The manual states (see J.A. 18) that the provision at issue here was drafted in response to an inquiry concerning the establishment of a separate MNIL for two adults; the manual surmised that this question was "similar" to the establishment of an MNIL for a family of one, a question that had been addressed in response to an inquiry made in 1976 (*ibid.*). There are, to be sure, similarities between setting MNILs for families of one and two. But there are also substantial differences, which the manual provision ignored. The most important distinction is that Congress dealt separately with each, in different sections of the Social Security Act. Section 1903(f)(1)(B)(i), which is at issue here, and which establishes the 133⅓% cap in relation to AFDC families of the "same size," addresses family sizes for which the state's AFDC program has specific income levels. The statutory prescription for establishing the MNIL for a family of one is contained in Section 1903(f)(3); it does not

4. There is nothing persuasive about the verbal and logical gymnastics in which the court of appeals engaged in an effort to fit the manual provision into the mold of a regulation. The court suggested, for example, that notice-and-comment procedures were not applicable here because the manual provision concerns matters relating to "public benefits" (see 5 U.S.C. 553(a)(2)). But in 1971 the Secretary had voluntarily waived the "public benefits" exception by formally stating that HHS regulations would comply with the APA procedural requirements. See 36 Fed. Reg. 2532 (1971). Quite apart from the question whether this voluntary waiver is binding on the Secretary to the same degree as procedural requirements imposed directly by Congress (see, *e.g.*, *National Welfare Rights Organization* v. *Mathews*, 533 F.2d 637 (D.C. Cir. 1976)), the Secretary's decision not to subject the HCFA manual to notice-and-comment procedures plainly shows that *the Secretary* did not regard that manual as a regulation. And it is certainly no answer to infer, as did the court of appeals (Pet. App. 14a), that the Secretary in issuing the

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employ the 133⅓% cap based on a family of the "same size," since an AFDC family of one is not the norm and, as Congress anticipated, some states may not have established AFDC income levels for a family of one. Rather, Section 1903(f)(3) says that the state shall calculate its Medicaid MNIL for a family of one "on the basis of reasonable relationship to the amounts payable under such plan to families consisting of two or more persons" (42 U.S.C. 1396b(f)(3)). The manual thus appears to have erred in transposing to a family of two the statutory standard that applies to a family of one. This is also suggested by the manual's citation of 45 C.F.R. 248.4(b)(4)(ii)(A) (1976) as the source for the manual's description of " 'reasonably related' income levels." See J.A. 21. That regulation is expressly limited to single-member families.

manual simply "failed to abide by her predecessor's promise to adopt APA rulemaking procedures," for that is to posit a presumption of agency irregularity.

The court of appeals acknowledged, moreover, that the Freedom of Information Act does not exempt benefits-related regulations from the publication requirement. The court parried that thrust by asserting (Pet. App. 15a (citation omitted)) that the FOIA publication requirement attaches only where nonpublication " 'would adversely affect a member of the public,' " and that the HCFA manual, although unpublished, was nevertheless a valid "legislative rule." But putting to one side the question whether an agency's failure to publish a regulation in the Federal Register will invariably invalidate it, the Secretary's action in not publishing the instant manual provision plainly shows that the Secretary did not regard it as a "regulation" at all, least of all a regulation effectively revoking prior regulations duly promulgated under the APA.

5. The practical effect of the decision below will be to make every agency publication, however informal, a "potential regulation," and thereby wreak havoc on federal agencies and the public. Under the administrative regime contemplated by the court of appeals, the regulations set forth in the Federal Register and the Code of Federal Regulations will be subject to contradiction, revision or repeal by far less formal, and certainly less official, pronouncements made by lower-level employees. As Judge Kozinski put it, agency officials "will now have to guess which of their informal, unsigned, internal guidelines will be found 'exceptional' enough to outrank regulations" (Pet. App. 32a). That is surely not the law. *Schweiker* v. *Hansen*, *supra*; *Heckler* v.

Community Health Services, 467 U.S. 51, 63-64 (1984); *Federal Crop Insurance Corp.* v. *Merrill*, 332 U.S. 380, 384 (1947).

Even more damaging than this, perhaps, is the court of appeals' statement that anonymous, internal agency pronouncements retain "the force and effect of law" unless "repealed," or, possibly, until "removed from publication" (Pet. App. 13a, 16a). The manual provision at issue here was in fact deleted from the superseding HCFA regional manual issued in July 1980, three years before California proposed the instant plan amendment. Until the decision below, one would have thought that an agency's revision of its office manual would terminate whatever effect (binding or otherwise) a predecessor version might be deemed to have. Apparently not. Although the government in its petition for rehearing (at 9 n.3) informed the court of appeals that the HCFA manual had been revised and the relevant language deleted in 1980, the panel took no cognizance of that fact. The court seems to have held, in other words, that the Secretary must engage in formal notice-and-comment rulemaking to revise an office manual, even though the manual's supposed status as a valid "legislative rule" rested on the court's antecedent conclusion that notice-and-comment rulemaking was not required when the manual was issued in the first place.

C. The Secretary Cannot Be Estopped From Obeying The Law On The Theory That The State Relied On The Manual Provision At Issue

In their brief in opposition (at 4, 20, 21), respondents refer to California's supposed "reliance" on HCFA's regional office manual when it passed the 1983 amendment to California's Medicaid plan. These statements have the flavor of an "estoppel" argu-

ment. But the court of appeals found no estoppel, and respondents themselves seem to disavow any estoppel theory in another part of their brief. See Br. in Opp. 25. If that is so, assertions about California's "reliance" on the manual are completely beside the point.

In any event, it is clear that California did not in fact rely on the manual. The hearing officer found that California did not rely on it (J.A. 12, 14). The Administrator of HCFA agreed that "reliance was never established" (Pet. App. 44a), and the court of appeals did not disturb that finding. The manual provision upon which the legislature allegedly relied in 1983 had in fact been deleted from the manual in July 1980 (see page 38, *supra*); and the affidavit submitted by a "principal co-author of the bill in the [State] Assembly" makes no reference to the manual (J.A. 61). Moreover, California's legislative enactment itself evidences an awareness that the proposed amendment would be disapproved by federal authorities, for it contains explicit and rather unusual instructions to be followed by the state agency in the event the 1983 amendment was found to violate federal law (see note 4, *supra*).

The administrative record likewise demonstrates that California officials were well aware that the proposed 1983 amendment was contrary to federal law. The 133⅓% federal reimbursement cap was scarcely unknown to the State, since it was the basis for HCFA's disapproval of the "special income deduction" that California had employed prior to 1982 (see page 7, *supra*). While the 1983 amendment was pending before the California legislature, respondent Kizer's predecessor wrote to the Administrator of HCFA, advising that "[o]ur staff analysis

has concluded that this provision * * * exceeds the maximum limitation on Federal Financial Participation" specified in Section 1903(f) and 42 C.F.R. 435.1007 (C.A. App. 140-141; see *id.* at 135). An earlier "Decision Memo" prepared by the state agency acknowledged the perceived conflict with federal requirements and assessed several options that could be employed to secure the "intended results," including a proposal to "implement [the] State statute to the extent possible without incurring loss of federal monies" (*id.* at 135-138). Respondent Kizer's predecessor had advised the author of the pending California legislation that his agency opposed the amendment in question, stating that "we don't believe federal approval of [the Assembly bill] would be granted" (C.A. App. 327; see J.A. 54). The HCFA Administrator in September 1983 explicitly told California that its proposed adult-couple MNIL would exceed the 133⅓% cap of Section 1903(f), and respondents concede (Br. in Opp. 5) that the State was advised of the problems with the amendment well in advance of the legislative enactment.[15]

At bottom, respondents' reliance argument seems to be that, while state officials knew that California's proposed 1983 amendment would be disapproved by federal authorities, they were unsure what the exact basis of that disapproval would be. Respondent Kizer's predecessor had identified two potential prob-

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[15] The Chief of the Eligibility Policy Section of California's Department of Health Services (see C.A. App. 231) explained that her department had initially opposed implementing the 1983 amendments inasmuch as "every federal official and staff member that I talked to and all of our letters indicated there is no way they are going to approve it, it seemed like a futile exercise" (*id.* at 281).

lems with the state's proposal—that it would produce an adult-couple MNIL in excess of the 133⅓% cap of Section 1903(f), and that it arguably violated the "single standard" rule of Section 1902(a)(10)(C)(i)(III).[16] Respondents seem to argue that California "relied" on the expectation that its proposed plan amendment would be rejected as violative of the "single standard" provision, whereas the basis for the HCFA Administrator's rejection was in fact the 133⅓% federal cap. But that scarcely bolsters respondents' contention that the State Plan amendment should therefore have been approved.

II. THE SO-CALLED "DEFRA MORATORIUM" DOES NOT IMPAIR THE SECRETARY'S AUTHORITY TO DISAPPROVE CALIFORNIA'S PROPOSED MEDICAID PLAN AMENDMENT

The court of appeals overturned the Secretary's determination on the alternative ground (Pet. App. 16a-18a) that the Secretary was barred by the so-called "DEFRA moratorium" from disapproving California's proposed plan amendment. The court of appeals reasoned, in other words, that even if the HCFA field manual was not a "regulation," with the result that disapproval of California's proposal was mandated by Section 1903(f), the Secretary was nevertheless prevented from taking that course by Congress's action in 1984. This reasoning betrays a serious misunderstanding of both the Secretary's decision and the scope of the DEFRA provision.

1. As we have explained, the sole basis upon which the hearing officer and the HCFA Administrator relied in disapproving California's proposed plan

[16] We discuss the latter provision more fully in the context of the "DEFRA moratorium" below.

amendment was the 133⅓% cap established by Section 1903(f) of the Social Security Act, 42 U.S.C. 1396b(f). An altogether different question—not implicated in the agency's decision to disapprove California's proposal—may arise under Section 1902(a)(10)(C)(i)(III) of the Act, 42 U.S.C. 1396a(a)(10)(C)(i)(III). That provision, added to the statute in 1982, required that a state's Medicaid plan establish a "single standard" for determining income and resource eligibility. That latter provision was initially read by some HHS employees (though not by the Secretary) to require that a family of two consisting of one adult and one child must have the same Medicaid eligibility level as a family of two consisting of two adults. It was this interpretation of the "single standard" provision—*i.e.*, requiring that all families of the same size be treated identically under Medicaid, regardless of how many adults are in the family—that some Congressmen criticized as an "overly literal" reading of the enactment. See H.R. Conf. Rep. 98-861, 98th Cong., 2d Sess. 1367 (1984). And it was this interpretation of the "single standard" provision (and of another provision that had also been enacted in 1982)[17] that was the subject of the DEFRA moratorium enacted in 1984.

The DEFRA moratorium, Pub. L. No. 98-369, § 2373(c)(1), 98 Stat. 1112, reads as follows (emphasis added):

> The Secretary of Health and Human Services shall not take any compliance, disallowance, penalty, or other regulatory action against a State

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[17] The 133⅓% cap was of course enacted in 1967, some 15 years previously.

> during the moratorium period described in paragraph (2) by reason of such State's plan under title XIX of the Social Security Act being determined *to be in violation of section 1902(a)(10)(C)(i)(III) of such Act* on account of such plan's having a standard or methodology which the Secretary interprets as being less restrictive than the standard or methodology required under such section.

The "moratorium period" was defined as "the period beginning on the date of the enactment of this Act and ending 18 months" after the Secretary submitted a specified report to Congress. Pub. L. No. 98-369, § 2373(c)(2) and (3), 98 Stat. 1112.

By its terms, the DEFRA moratorium speaks only of regulatory action against a state under Section 1902(a)(10)(C)(i)(III) of the Social Security Act. The moratorium makes no mention of Section 1903(f), or of the 133⅓% cap set forth therein. As we have explained (note 6, *supra*), moreover, Section 1902(a)(10)(C)(i)(III) and Section 1903(f) impose wholly distinct limitations on a state's Medicaid plan. The former Section arguably requires that all Medicaid families of a given size must have the same income eligibility level; it thus focuses on relative entitlements within the Medicaid system. Section 1903(f), by contrast, specifies an absolute dollar cap on federal financial participation in Medicaid, linking the Medicaid eligibility of any family to the AFDC eligibility of a family of the same size. Thus, regardless of whether, under Section 1902(a)(10)(C)(i)(III), a two-person family consisting entirely of adults must be treated the same as a two-person family consisting of one adult and one child, Section 1903(f) says that federal financial participation will

not be available if the Medicaid MNIL for *either* family exceeds 133⅓% of the state's highest payment to a two-person family under its AFDC program.

2. The legislative history reinforces the statutory language. It shows that Congress not only limited the DEFRA moratorium to subjects other than those involved in this case, but also that Congress specifically rejected a proposal that would have accomplished the precise result that respondents obtained in the court of appeals.

Some members of the House of Representatives did disagree with the Secretary's implementation of Section 1903(f). The House Committee on Energy and Commerce therefore recommended amending Section 1903(f) to provide explicitly that a state could set its Medicaid income level for two adults by reference to the State's highest AFDC payment ordinarily made to a family of three. H.R. 4136, 98th Cong., 1st Sess. § 211 (1983). But that amendment was rejected in conference, and DEFRA contains no such provision. The Conference Report explained (H.R. Conf. Rep. 98-861, *supra*, at 1361):

> Present law
>
> Medically needy income levels for an SSI-related family of two adults with no income or resources, many [*sic*] be set at a level no higher than 133⅓ percent of the AFDC standard for a two-person family with no income or resources.
>
> House bill
>
> The House bill permits States to establish medically needy levels for a family of two adults up to 133⅓ percent of the three-person AFDC standard.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

Respondents have attempted to disengage themselves from the consequences of that legislative determination by attributing to Congress motives that appear nowhere in the legislative history. Thus, respondents suggest that Congress rejected the proposed House amendment to Section 1903(f) because it was "too limited" and would be redundant in light of the "broader" moratorium (Br. in Opp. 6). But, as the plain language and the legislative history show, the moratorium provision is not as broad as respondents propose. To the contrary, it is expressly limited to Section 1902(a)(10)(C)(i)(III), and it cannot rationally be thought to apply by implication to Section 1903(f), since Congress expressly *declined* to amend Section 1903(f) in that way.[18]

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[18] This Court recognized in *Atkins* v. *Rivera*, slip op. 12 n.10, that Congress's sole purpose in enacting the DEFRA moratorium was to override regulations the Secretary had issued following the Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, 95 Stat. 357. See H.R. Conf. Rep. 98-861, 98th Cong., 2d Sess. 1366-1368 (1984); *Camacho* v. *Perales*, 786 F.2d 32, 42 (2d Cir. 1986). The regulations at issue in this case were initially promulgated in 1971, and have been unchanged since 1978; these regulations were accordingly not affected by TEFRA or by the related DEFRA moratorium.

The context of the DEFRA moratorium further bolsters the conclusion that Congress did not intend to limit the Secretary's authority to enforce the 133⅓% cap. DEFRA was, after all, primarily a deficit reduction measure. There is, therefore, no reason why Congress would have enacted, as

Respondents' remaining contentions are similarly flawed by their deliberate confusion of the "single standard" provision with the 133⅓% cap. For example, respondents point to language in the Conference Report concerning "adult couple MNILs" (Br. in Opp. 6). That report states that the moratorium was directed inter alia at the "position that the 'single standard' requirement of the TEFRA amendment prohibits States from establishing less restrictive medically needy income levels for single adults and couples." H.R. Conf. Rep. 98-861, *supra*, at 1367 (quoted in Br. in Opp. 7-8). This statement obviously refers only to the TEFRA "single standard" provision; it does not refer to the 133⅓% cap. As we have noted, an "adult couple MNIL" like California's may be objectionable on two distinct grounds: (1) in relative terms, because it treats some two-person families better than other two-person families for Medicaid purposes, in violation of the "single standard" rule; and (2) in absolute terms, because it sets Medicaid benefits for a two-person family at a level higher than 133⅓% of the maximum AFDC benefits for a two-person family, in violation of Section 1903(f). In addressing "adult couple MNILs" in the context of the DEFRA moratorium, Congress was referring only to the former ground of invalidity. This case concerns the latter.[19]

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part of budget-cutting legislation, a provision that would preclude the Secretary from enforcing the statutory cap on federal financial participation in Medicaid without at least explicitly stating its intent to do so.

[19] Even as to the effect of the DEFRA moratorium on the Secretary's powers under Section 1902(a)(10)(C)(i)(III), Judge Kozinski noted (Pet. App. 34a) that the moratorium "prohibits the Secretary from taking any regulatory action

In sum, there is no basis for assuming that Congress intended the DEFRA moratorium to apply to the situation involved here. Section 1903(f) is not within the scope of the moratorium's statutory language, is not mentioned in the Conference Report's description of the moratorium's purpose, and is a provision that the Conference Report expressly refused to amend only six pages earlier. Cf. *Gulf Oil Corp.* v. *Copp Paving Co.*, 419 U.S. 186, 200 (1974) (Conference Committee's deletion of phrase from bill "strongly militates against a judgment that Congress intended a result that it expressly declined to enact."). And once the clear statutory distinction between Section 1903(f) and Section 1902(a)(10)(C)(i)(III) is recognized, respondents' attempt to draw support from DEFRA's legislative history evaporates.

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against a 'State's [Medicaid] plan.'" Since California's "proposed amendment does not become part of its plan [until approved by the Secretary]," Judge Kozinski observed, the State "therefore cannot benefit from the moratorium" in this case. *Ibid.*

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted.

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In The

Supreme Court of the United States

October Term, 1987

Otis R. Bowen, Secretary of Health and Human Services,

Petitioner,

v.

Kenneth Kizer, Director of the California Department of Health Services, *et al.*,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

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QUESTIONS PRESENTED

1. Whether, when Congress has specifically permitted states to employ a separate and higher Medicaid income standard for adult couples than that used for a family of a parent and child, the Secretary may refuse to approve California's Medicaid state plan amendment establishing such a standard?

2. Whether the Secretary could disapprove California's income standard for adult couples, when that standard was formulated in accordance with an interpretative guideline promulgated by HHS' Health Care Financing Administration pursuant to authority delegated by the Secretary, when the Secretary's own regulations contemplate that states may rely upon such guidelines, and when the guideline is consistent with the language of Title XIX of the Social Security Act and is reasonably related to the purposes of the Act?

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STATUTORY AND REGULATORY PROVISIONS INVOLVED

The relevant portions of § 1902(a)(10)(C) of the Social Security Act ("the Act"), 42 U.S.C. § 1396a(a)(10)-(C), of § 1903(f) of the Act, 42 U.S.C. § 1396b(f), of 42 C.F.R. § 435.1007, and of California Welfare and Institutions Code § 14005.12 are set out in the Appendix to the Petition. (Pet. App. 46a-49a). Section 2373(c) of the Deficit Reduction Act of 1984, Pub.L. 98-369, 98 Stat. 1112 ("DEFRA") in its entirety, the report of the Conference Committee on that provision, 45 C.F.R. § 201.3(d), and HHS' Regional Office Manual 2572-D are set out in the Appendix to the Brief in Opposition. (Br. in Opp., App. 1-10). The ROM provision is also found at pages 18-21 of the Joint Appendix. 42 CFR § 435.814 (1980) and § 435.812 (1981), in relevant part, are set out in the Appendix to this brief.

STATEMENT OF THE CASE

Respondents take issue with Part B(2) of petitioner's statement of the case, (Pet.Br. at 10-12), and with the related material set forth at pp. 38-41 of his brief. Petitioner erroneously asserts that the State has consistently acknowledged its adult couple MNIL to be inconsistent with Title XIX and with the Secretary's regulations.

1983 Stat. Ch. 323, § 124.7(a) (Pet.Br. at 9, n.4) does demonstrate the State Legislature's awareness that the proposed amendment would likely be disapproved, at least initially, by federal authorities—a fact which is hardly sur-

prising given the position which HCFA took on the legislation during the spring of 1983. (See pp. 10-11, *infra*). Nevertheless, in § 124.7, the Legislature emphasized its intent that the statute be implemented immediately upon enactment, and that the Department of Health Services take all steps necessary to appeal an adverse determination as to its validity. The Legislature thus demonstrated its view that ultimately the adult couple MNIL, based as it was upon a HCFA guideline, would be upheld.

The subsequent actions of the Department of Health Services must be viewed in light of HCFA's repeated assertions to that agency that ROM 2572-D was no longer valid.[1] Concerned that the State would lose federal funds if the adult couple MNIL was implemented, DHS sought a "formal ruling" in an attempt to avoid implementation, *see* Cal. Welfare & Inst. Code § 11003, and explored other options for dealing with the problem. Ultimately, however, pursuant to an agreed upon court order, *Minor v. Rank*, No. H 93254-7 (Alameda County Superior Ct., 1983), DHS did implement the statute. At all stages of this proceeding, the agency defended the adult couple MNIL on the ground that it is consistent with Title XIX as construed in ROM 2572-D, and is expressly permitted under DEFRA.

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[1]The chronology set forth at pp. 39-40 of petitioner's brief is incorrect: The letter (C.A. App. 140) and decision memo referred to there were prepared in late August, 1983, after the adult couple MNIL bill was enacted.

SUMMARY OF ARGUMENT

1. The Secretary focuses almost exclusively upon the Court of Appeals' holding that ROM 2572-D has legislative effect. However, the court did not rest its judgment solely upon that ground, but also relied upon § 2373(c)(1) of DEFRA ("the moratorium"). In its report on that provision, which originated in conference, the Conference Committee specifically and expressly permitted states to adopt adult couple medically needy income levels ("MNILs") during the period of the moratorium.

Petitioner now argues for the first time that Congress only intended to permit states to establish MNILs for adult couples which would not exceed 133⅓% of the AFDC grant to a family of two. His construction of DEFRA ignores certain crucial facts: First, Congress intended to override HHS' disapproval of specific state proposals to establish adult couple MNILs, and no state was proposing to maintain a standard set below 133⅓% of the AFDC grant for two—on the contrary, California and Nebraska, the only states contemplating adult couple standards, wished to base them on the AFDC grant for three. Second, in 1981, HHS adopted regulations permitting states to adopt adult couple MNILs set at 133⅓% of the AFDC grant for two. In 1982, Congress specifically disapproved those regulations. Petitioner's reading of DEFRA would require this Court to find that Congress intended to reverse an action which it had taken only two years earlier without comment or explanation.

There is no evidence whatsoever to support petitioner's revisionist view of Congress' intent. Indeed, his construction is inherently improbable. The language of

the DEFRA conference report and the history of the moratorium provision demonstrate that Congress intended to permit states to do precisely what California has done. The court below correctly reversed the Secretary's decision disapproving the adult couple MNIL on that basis alone.

2. Although ROM 2572-D is not a regulation with legislative effect, it is an interpretative regulation entitled to deference. It is not an "informal, internal communication by [a] lower level employee", as petitioner asserts, but a guideline for approval of state Medicaid plans promulgated by the Health Care Financing Administration ("HCFA"), a "principal operating component" of HHS to which the Secretary has delegated the authority vested in him under Title XIX of the Social Security Act. Because the Secretary's own regulations contemplate that states will refer to and rely upon such guidelines in drafting their Medicaid state plans, 45 CFR § 201.3(d), the ROM provision is entitled to more than the ordinary weight accorded such regulatory materials. The Secretary could disapprove California's state plan amendment, which followed the formula set out in ROM 2572-D, only if the provision had been repealed or was inconsistent with his regulations or with the Act.

There is no evidence in the record to support petitioner's contention that the provision was repealed in 1980—a contention which was first asserted in a footnote in the petition for rehearing below. Indeed, the record is specifically to the contrary: In April, 1983, the Director of the Bureau of Eligibility, Reimbursement and Coverage, the entity within HCFA responsible for reviewing and developing Medicaid policy, stated that ROM

2572-D had not yet been repealed. And in October, 1983, the House reviewed the guideline and found it to be "sound"—a determination subsequently adopted in DEFRA.

The court below correctly held that ROM 2572-D is consistent with § 1903(f) and with 42 CFR § 435.1007. The statute uses the highest amount which would "ordinarily" be paid to a family of the same size under a state's AFDC program as the baseline for setting medically needy MNILs. The Secretary's regulation adds nothing to the statute, but simply repeats its formulation. As HCFA found in 1979, because states do not "ordinarily" pay AFDC grants to families of two adults, an MNIL based upon the AFDC grant for a family of two does not adequately take into account the needs of aged and disabled married couples.

In § 1903(f)(1)(B)(i), Congress delegated to the Secretary broad authority to set standards as necessary to resolve such disjunctions between the AFDC and Medicaid programs. In ROM 2572-D, HCFA, pursuant to the Secretary's delegation of the authority vested in him under Title XIX, properly interpreted the ambiguity inherent in the statute and the Secretary's regulation in favor of granting states flexibility to meet the needs of their aged and disabled medically needy Medicaid recipients. And in 1984, Congress ratified that interpretation when it permitted states to establish adult couple MNILs set no higher than 133⅓% of the AFDC grant for a family of three.

ARGUMENT

I. CONGRESS HAS SPECIFICALLY PERMITTED STATES TO ADOPT ADULT COUPLE MNILs SUCH AS CALIFORNIA'S

A. In the DEFRA Moratorium, Congress Repudiated HHS' Disapproval of California's and Nebraska's Adult Couple MNILs

In the conference committee report to the DEFRA moratorium, Congress disapproved HHS' "overly literal" enforcement of the "single standard" and "same methodology" language added to § 1902(a)(10)(C)(i)(III) of the Act by the Tax Equity and Fiscal Responsibility Act of 1982, P.L. 97-248 ("TEFRA"). The Committee made specific reference to HHS' refusal to approve "less restrictive medically needy income levels for single adults and couples" as one of the problems which would, at least temporarily, be resolved by the moratorium on enforcement of the TEFRA amendment:

> For example, . . . the Department has taken the position that the "single standard" requirement of the TEFRA amendment prohibits States from establishing less restrictive medically needy income levels for single adults and couples because this would result in differences in medically needy income levels among groups of the same family size depending on relative numbers of adults and children.
>
> The Department's overly restrictive interpretation of section 137[(b)](8) of TEFRA has posed grave administrative problems for the States and threatens to cause great hardship for applicants and beneficiaries. . . . The conferees have therefore decided to impose a moratorium on the Department's implementation of the TEFRA amendment until the Congress has an opportunity to study and legislate on the mat-

ter. H.R. Rep. 98-861, 98th Cong., 2d Sess. 1367-68 (1984) (Br.in Opp., App. 4-5).

As the language of the committee report demonstrates, Congress was not acting in a vacuum. It was addressing HHS' disapproval of specific proposals to adopt adult couple MNILS. Only two states, California and Nebraska, had proposed to do so, and each sought to establish an adult couple income standard set at 133⅓% of the AFDC grant amount for a family of three. It was these proposals which Congress wished HHS to approve.

1. California's Adoption of the Adult Couple MNIL

After California repealed its special income deduction in 1982 (Pet. Br. at 7), the MNIL for two persons was set at 133⅓% of the AFDC grant for two, or $544. In contrast, categorically needy aged, blind, and disabled couples on SSI/SSP were, at the time, receiving $838 per month to meet their non-medical needs.[2] (C.A. App. 336, 337). For the first time, as a condition of receiving Medicaid (known in California as Medi-Cal), medically needy pensioners, blind and disabled people were required to live on amounts far below that allotted to SSI recipients.

During the early part of 1983, the California Legislature's Assembly Committee on Aging and Long Term Care held public hearings on the effect of recent changes in the Medi-Cal program. Those hearings focused in large part

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[2]The amount of the SSI grant is set by federal law. States are, however, free to supplement the federal amount with state funds. 42 U.S.C. § 1382e. The combined federal-state payment is referred to as SSI/SSP (State Supplemental Payment).

on the impact of the sharp decrease in the MNIL. Aged and disabled recipients and their advocates testified that sick people were unable to afford both their non-medical expenses and their expenses for out-patient care, such as doctor's visits and prescription drugs. The testimony indicated that the reduced MNIL was exacerbating widespread mainutrition among the elderly, and, in some cases, was causing unnecessary institutionalization. (C.A. App. 337-338, 340, 611-822).[3]

As a result of the public outcry concerning the impact of the reduced income standards, (C.A. App. 338-39), the Legislature adopted a new formula to determine the MNIL for adult couples, to ensure "that the income levels for maintenance need for medically aged, blind, and disabled adults, in particular, shall be based upon amounts that adequately reflect their needs." Welfare & Inst. Code § 14005.12(a),(c), as amended by 1983 Stat. Ch. 323, § 124.6. (Pet. App. 49a).[4] The new adult couple MNIL of $709 per

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[3]The declarations found at J.A. 36-57, describing the serious hardship which the reduced MNIL caused to the individual respondents and to other aged and disabled people, are typical of the testimony at the public hearings.

[4]Petitioner contends that California could have raised its AFDC grants rather than establish an adult couple MNIL. (Pet. Br. at 8). This attempt to second guess the State Legislature, however, founders on reality. California already pays AFDC grants which are among the highest in the nation, HHS. *Characteristics of State Plans for Aid to Families with Dependent Children*. SSA No. 80-21235 (1986) and, in addition, is one of the few states to provide an automatic annual cost of living increase to its AFDC families. Cal. Welfare & Inst. Code § 11453. Moreover, there are far more AFDC recipients than there are medically needy aged and disabled couples: In September,

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month (J.A. 24) was based upon Section 2572-D of the Regional Office Manual ("ROM") promulgated by HHS' Health Care Financing Administration ("HCFA") (J.A. 18-21), which provided that states may establish adult couple MNILS set as high as 133⅓% of the AFDC grant for a family of three "in order to effectively acknowledge the greater maintenance needs of an adult as opposed to those of a child." (*Id.* at 21).[5]

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1983, for example, there were 1.6 million Californians receiving AFDC, (Cal. Department of Social Services, Statistical Services Branch, *Public Welfare in California*, Statistical Series PA3-288, Table 1 (Sept. 1983)), while there were only 110,726 aged, blind and disabled medically needy Medi-Cal recipients, (Cal. Dept. of Health Services, *Cumulative Certified CID Eligibles Excluding Unborns, July '83 through Dec. '83* (Dec. 1984)). The State could hardly have been expected to raise the AFDC grant amount for a family of two—a solution which would have necessitated adjustments for all other family sizes as well—in order to address the needs of aged and disabled Medi-Cal recipients who do not even receive AFDC benefits.

Alternatively, petitioner contends that California could have elected to pay for its adult couple MNIL with state funds. The premise of the Medicaid program, however, is that states will receive federal financial participation for Medicaid benefits provided to eligible recipients. *Harris* v. *McRae*, 448 U.S. 297, 308-11 (1980). ROM 2572-D, which formed the basis for California's legislation, provided a methodology by which the State could obtain federal assistance to meet the needs of its medically needy aged and disabled population. The State Legislature, anticipating federal funding based upon that guideline, declined to devote scarce state funds in the absence of federal sharing.

[5]Petitioner contends that the State did not rely upon the ROM provision. This argument is misdirected insofar as it is calculated to show that the principle of estoppel is inapplicable, since respondents raise no estoppel claim. See n.23, *infra*. As a factual matter, the argument is inconsistent with the terms of the state statute, which is clearly modeled upon ROM

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While California's legislation was still pending, HHS' Regional Office in San Francisco, aware that the State was preparing legislation modeled upon ROM 2572-D, requested guidance from HCFA's Bureau of Eligibility, Reimbursement and Coverage ("BERC") concerning the validity of the ROM provision. (Br. in Opp., App. 11-12). The Regional Office suggested that the ROM provision was no longer valid in light of § 1902(a)(10)(C)(i)(III) of the Act as amended by TEFRA. That provision, (Pet. App. 47a), requires state plans to describe "the single standard to be employed in determining income and resource eligibility for all such [medically needy] groups."

On April 15, 1983, in a document entitled "Policy Information For All Regions," the Director of the BERC advised the Regional Administrator: "Establishing different medically needy levels that would vary by family composition, would in effect, result in application of more than a single standard for a group," and would thereby violate TEFRA. (Br. in Opp., App. 13-14).[6] The Regional

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2572-D's formula, and with the record, which demonstrates that the Legislature was attempting to ameliorate the impact of the previous MNIL reduction in a manner which conformed to federal law as interpreted in the ROM. C.A. App. 327, 328 (letter from Director of DHS to author of bill, with analysis indicating that "the methodology proposed in [the bill] is based on [ROM 2572-D]"); Br. in Opp., App. 11-12 ("[T]he State is drafting legislation to raise the [MNILs] in accordance with ROM [2572-D]").

[6]The BERC, an office within HCFA, "reviews existing policy and develops new policy" concerning Medicaid eligibility. 46 Fed. Reg. 56929 (Nov. 19, 1981) (functions of Bureau of Pro-

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Office, in turn, advised the California Department of Health Services of HCFA's interpretation. (Br. in Opp., App. 15-16). However, the California Legislature adopted the adult couple MNIL, and the Department of Health Services subsequently submitted its state plan amendment to HHS.

2. Nebraska's Attempt to Adopt an Adult Couple MNIL

In September, 1982, the Governor of Nebraska requested permission from HCFA to raise its MNIL for the State's aged and disabled medically needy adult couples. The State noted that its MNIL of $375 per month "does not adequately reflect the needs of this group of people whether they live independently or in an alternate care facility in the community." The State proposed to adopt an adult couple MNIL set either at the State's SSI/SSP level of $552 per month, or at 133⅓% of the AFDC grant for three. (Br. of Amici Curiae Maryland et al., App. A-1). On May 16, 1983, HCFA advised the Governor that, by adopting an adult couple MNIL set at 133⅓% of the AFDC grant for three, the State would violate § 1903(f) of the Act and TEFRA's single standard requirement. (*Id.*, App. A-6).

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gram Policy, subsequently renamed BERC). *See* p. 23, *infra*. The Regional Office was required to seek BERC's guidance by 45 C.F.R. § 201.3(b) ("State plan material on which the regional staff has questions concerning the application of Federal policy is referred with recommendations as required to the central office for technical assistance.")

3. Congress Responds By Adopting the DEFRA Moratorium

Congress had been alerted to HHS' new policy repudiating ROM 2572-D, as set forth in HCFA's letter of April 15, 1983. In October, 1983, the House Energy and Commerce Committee reported a bill to the House of Representatives which permitted states to adopt an adult couple MNIL as California had done, and as Nebraska had proposed. H.R. 4136, 98th Cong., 1st Sess. § 211.

The Committee specifically approved ROM 2572-D's interpretation of § 1903(f), finding that "the policy is sound." H.R. Rep. 98-442, Pt. 1, 98th Cong., 1st Sess 51 (1983) (Br. in Opp., App. 18, 19). On the understanding that HCFA was now repudiating the ROM provision because it apparently conflicted with TEFRA's single standard requirement, the Committee stated its intent to create a limited exception to TEFRA: "In short, the Committee amendment would relax the single standard requirement only in the limited circumstance in which a State sets its medically needy income level for two adults *in excess of 133 1/3% percent of the highest cash payment ordinarily made to a family of two under the State's AFDC program.*" *Id.* at 52 (Br. in Opp., App. 20) (emphasis added). The House passed the Committee's provision in H.R. 5394, 98th Cong. 2d Sess. § 361 (1984) (Br. in Opp., App. 17).

H.R. 5394 went to conference with the Senate. The Conference Committee shared the House's concern regarding HHS' refusal to approve California's and Nebraska's proposed adult couple MNILs. However, the Committee declined to adopt the permanent but limited exception to TEFRA's single standard requirement contained in the House bill. The Committee was concerned that HHS'

"overly literal" reading of TEFRA had created "grave administrative problems for the States" and had "threaten[ed] to cause great hardship for applicants and beneficiaries" in a number of respects, including but not limited to adult couple MNILs. (Br. in Opp., App. 4-5). Therefore, the Committee determined to enact a broader but time-limited moratorium, during which the states would be permitted to adopt a variety of "less restrictive" standards and methodologies for their medically needy programs than those required by a strict reading of TEFRA. Accordingly, Congress forbade the Secretary from taking "any compliance, disallowance, penalty, or other regulatory action" against a state during a moratorium period of approximately 30 months because the state uses any standard or methodology which the Secretary considers to violate TEFRA's "single standard" or "same methodology" requirement. DEFRA, § 2373(c)(1) (Br. in Opp., App. 1).[7] Congress specifically included "less restrictive medically needy income levels for single adults and couples" in that prohibition. See p. 6, *supra*.

B. The Moratorium Addressed And Was Intended to Reverse HHS' Refusal to Approve Proposals to Establish Adult Couple MNILs Based Upon the AFDC Grant for Three

Petitioner has contended throughout that the DEFRA moratorium does not apply here. In the court below, he was content to argue that his final decision did not implicate TEFRA's single standard/same methodology lan-

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[7]Under § 2373(c)(2), the moratorium ends 18 months after the Secretary submits the report required under § 2373(c)(3). To this day, the Secretary has not submitted that report, although it was due in July, 1985.

guage, and otherwise simply to ignore the language of the Conference Report expressly permitting states to establish adult couple MNILs. In this Court, he previously argued, in addition, that the moratorium did not apply because it concerned only resources, not income standards. (Pet. at 18).[8] Now, he adopts yet another approach: He argues for the first time that Congress did intend to permit adult couple MNILs during the moratorium period, but only if they are set below 133 1/3% of the state's AFDC grant level for a family of two. The history of the moratorium provision, however, is flatly inconsistent with this explanation for two reasons: First, Congress was rejecting HHS' refusal to approve California's and Nebraska's proposals to establish adult couple MNILs based upon AFDC grants for three;[9] second, only two years earlier, Congress had disapproved HHS regulations which would have permitted states to establish adult couple MNILs at or below 133 1/3% of the AFDC grant for two. Thus, there is not a scintilla of evidence in the history of the statute to support petitioner's new version of the facts.

1. The House, which originated the legislation to permit adult couple MNILs, was reacting to HCFA's "Policy Information for All Regions" letter of April 15, 1983 asserting that ROM 2572-D was no longer valid in light of

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[8]Respondents have previously refuted that and related contentions. (Br. in Opp. at 12-15). Insofar as petitioner's brief on the merits abandons the assertions made in his petition, they are not again addressed here.

[9]No other states were attempting to adopt adult couple MNILs during the period that Congress was addressing the matter, and no states maintained such standards at that time.

TEFRA.[10] The House bill was drafted and passed hard upon the heels of that letter, and was clearly intended to repudiate the position set forth therein:

> Prior to the enactment of the Omnibus Budget Reconciliation Act of 1981, P.L. 97-35, Federal guidelines allowed States to set the medically needy income levels for two adults at an amount equal to 133 1/3 percent of the AFDC payment for a family of one adult and two children. (HCFA-ROM-31 [2572-D], June 19, 1979). This guideline recognized that a State could find that an adult had greater maintenance needs than a child, and could set its medically needy income level for two adults accordingly.
>
> *It is the understanding of the Committee that [HHS] has reversed its policy on this point and taken the position that a medically needy income level for two adults could not, consistent with Federal law, be set at an amount equal to 133 1/3 percent of the amount ordinarily paid to an AFDC family of three without income or resources. The Department's new policy appears to be that the medically needy income level for two adults may not be set higher than an amount equal to 133 1/3 percent of the amount ordinarily paid to an AFDC family of two* . . . .
>
> . . .
>
> The Committee bill makes clear that [TEFRA's] single standard requirement does not justify a rejection of the valid 1979 policy. . . . H.R. Rep. 98-442 (Br. in Opp., App. 18-19) (emphasis added).

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[10]The House bill was enacted well before December, 1983, when HCFA, in initially disapproving California's proposed state plan amendment, based its position solely on § 1903(f), rather than on TEFRA. (J.A. 25). Even then, HCFA's position was unclear: In June, 1984, the agency again relied upon TEFRA in its prehearing brief in the administrative proceeding. (C.A. App. 486-89).

In permitting states to adopt adult couple MNILs, the Conference Committee addressed the same problem with which the House was initially concerned. The Committee was also reacting to the policy set forth in HCFA's letter of April 15, 1983:

> Similarly, *the Department has taken the position* that the "single standard" requirement of the TEFRA amendment prohibits States from establishing less restrictive medically needy income levels for single adults and couples . . . . H.R. Rep. 98-861 (Br. in Opp., App. 5) (emphasis added).

In order to "reinstate the Department's previous policy", as the House proposed to do, (Br. in Opp., App. 19), the Committee did not find it necessary to amend § 1903(*f*): Like the House, the Committee had before it ROM 2572-D, in which HCFA had already interpreted that provision to permit adult couple MNILs based upon the AFDC grant for a family of three. Rather, the Committee overruled HCFA's position that TEFRA invalidated the ROM, so as to compel the agency to approve the proposals which it had previously rejected pending the outcome of the moratorium. The Committee's solution differed from the House's only with respect to its duration: The Committee preferred to "relax the single standard requirement" temporarily, while the House would have done so permanently.

2. Prior to 1981, HHS' regulations required states to use "an income standard to determine eligibility for two persons", set at the highest of the SSI grant level, the SSI/SSP level (if applicable), or the AFDC grant for two; however, if that amount exceeded the cap on federal financial participation ("FFP") set forth in 42 CFR § 435.1007, the State was permitted to set its MNIL for *all* medically needy groups at, but not below, the 133⅓% cap. 42 CFR

§ 435.814 (1980) (App. 1, hereto).[11] Under this regulation, the higher SSI/SSP grant levels (Pet.Br. at 5, n.1) worked to the benefit of AFDC-linked medically needy families of two.

In 1981, after passage of OBRA, HHS amended its regulations to permit states to use *either* a single MNIL for all medically needy groups set at the level required under its previous regulation, *or* a different standard for each covered medically needy group (i.e., aged, blind, disabled, and families with children). States which chose the latter option were required to set the standard for each group at the income standard for the cash program related to that group or, if that amount exceeded the limit on FFP, at, but not below, the 133⅓% limit. 42 CFR § 435.812 (1981) (App. 2, hereto). The effect of this regulation was to permit states to establish a lower income standard for a family of a parent and child than for a family of two medically needy aged or disabled adults, thereby making it more difficult for the AFDC-linked medically needy family to qualify for Medicaid.[12] For example, the adult couple MNIL could be set at 133⅓% of the AFDC grant for two, while the standard for AFDC-linked medically needy families could be set at 100% of the AFDC grant for two.

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[11]This regulation was based upon the statutory requirement that medically needy standards be "comparable" for all medically needy groups. *See Hogan v. Heckler*, 769 F.2d 886, 894-95 (1st Cir. 1985), *cert. den.*, 477 U.S. —, 92 L.Ed.2d 715 (1986). ROM 2572-D established a limited exception to this principle so as to permit states to achieve greater comparability between aged and disabled categorically and medically needy groups, as contemplated by the pre-OBRA language of § 1902(a)(10)(C). *Id.* at 895.

[12]A reduced medically needy income standard results in an increase in the family's monthly liability for medical expenses. See Pet.Br. at 7, n.3.

In 1982, when it passed the "single standard/same methodology" language of TEFRA, Congress specifically disapproved 42 CFR § 435.812 as amended and mandated HHS to return to the pre-1981 regulations. H.R. Rep. 97-757, Pt. 1, 97th Cong., 2nd Sess. 13 (1982) ("The Committee bill reaffirms the financial requirements previously in effect for the medically needy (42 C.F.R. sec. 435.800-435.845)"). *See Atkins v. Rivera*, 477 U.S. —, 91 L.Ed.2d 131, 142-43 (1986); *Hogan v. Heckler, supra*, 769 F.2d at 901. Thus, after TEFRA, HHS could not approve an adult couple MNIL set at 133⅓% of the AFDC grant for two persons, unless the standard for all medically needy families was set at that level.[13]

Petitioner contends that in DEFRA, Congress allowed states to establish adult couple MNILs set at 133⅓% of the AFDC grant for two, and to establish MNILs for other families of two below that amount. In order to accept that contention, one would have to find that Congress reversed its two-year old action without comment or explanation. This interpretation of DEFRA is improbable in the extreme: In fact, Congress intended to permit separate adult couple MNILs *only* if they were set *above* 133⅓% of the AFDC grant for two. *See* H.R. Rep. 98-442, *supra* (Br. in Opp., App. 20). Any other interpretation would be inconsistent with the stated purpose of the moratorium provision.

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[13]H.R. Rep. 98-442 reflects that understanding. By means of a detailed example, the House Committee emphasized that the proposed amendment would make no change in existing law: If a state set its MNIL for two adults at 133 1/3% of the AFDC grant for two, the income level for AFDC-related medically needy families would have to be the same. (Br. in Opp., App. 20).

In states such as California and Nebraska, the only two states proposing to adopt adult couple MNILs, the measure, as petitioner construes it, would not have improved the lot of the medically needy aged, blind and disabled, since, under 42 CFR § 435.814, in its 1980 version, the MNIL for those groups could not go below 133⅓% of the AFDC grant for two in any event.[14] Other states whose MNILs for two were set below 133⅓% of the AFDC grant for two were at all times free to raise the income standards to that level, without further congressional action. As petitioner interprets it, DEFRA would not have given states additionally flexibility to meet the needs of aged and disabled medically needy people, but would only have permitted them to lower the MNIL for other medically needy families. Yet, in enacting the moratorium, the Conference Committee explicitly stated that the moratorium was intended to allow only "less restrictive", not "more restrictive" standards and methodologies than those required under TEFRA. (Br. in Opp., App. 6).

The purpose of DEFRA's moratorium was to obviate the "great hardship for applicants and beneficiaries" caused by HHS' "overly restrictive interpretation of section 137[b](8) of TEFRA." H.R. Rep. 98-861 (Br. in Opp.,

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[14]For example, California provides Medicaid to aged and disabled recipients of state supplements. (See n.2, *supra*). The SSI/SSP grant amount is higher than 133 1/3% of the AFDC grant for a family of two. Thus, under 42 CFR § 435.814(b) (1980), the MNIL for all medically needy families of two could not fall below the latter amount.

App. 5).[15] With respect to adult couple MNILs, Congress intended to reject the policy set out in HCFA's communication of April, 1983, and to do, on a temporary basis, what the House had proposed to do permanently—to "relax the single standard requirement only in the limited circumstance in which a State sets its medically needy income level for two adults in excess of 133⅓ percent of the highest [AFDC] cash payment ordinarily made to a family of two".[16]

II. UNDER 45 CFR § 201.3(d), CALIFORNIA COULD PROPERLY FORMULATE ITS ADULT COUPLE MNIL IN ACCORDANCE WITH ROM 2572-D, A VALID GUIDELINE PROMULGATED PURSUANT TO THE SECRETARY'S DELEGATION OF AUTHORITY TO HCFA

"[T]his Court reviews judgments, not opinions, . . ." *Chevron, U.S.A., Inc. v. Natural Resources Defense Coun-*

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[15]Petitioner haltheartedly contends that the moratorium was intended to apply only to existing state plans, and not to plan amendments submitted after passage of DEFRA (Pet.Br. at 46, n.19), a contention resoundingly rejected in the court below. (Pet.App. 18a). The last sentence of the conference committee report, stating the conferees' expectation that states "will be reasonable" in establishing less restrictive standards and methodologies, completely undermines petitioner's argument. (Br. in Opp., App. 6). *See also* H.R. Rep. 100-85, Pt. 1, 100th Cong., 1st Sess. 22-25 (1987); S.Rep. 99-520, 99th Cong., 2d Sess. 20 (1986) (both expressly repudiating HHS' position).

[16]The fact that DEFRA was, in its overall outlines, a budget reduction measure does not lend support to the Secretary's argument. In other provisions of DEFRA, Congress expanded Medicaid coverage. *See, e.g.*, § 2361 (expanding coverage for pregnant women and children); §2362 (insuring immediate coverage for eligible newborn children). And in the moratorium provision itself, Congress gave the states full authority to use less restrictive standards and methodologies than those used in the cash assistance programs, with the sole limitation that "the States will be reasonable. . . ." (Br. in Opp., App. 6).

cil, Inc., 467 U.S. 837, 842 (1984). Although the court below gave ROM 2572-D "legislative effect," it could well have rested its judgment upon the ordinary deference which this Court and the courts of appeals have given similar regulatory material. Had it done so, the only question would have been whether the ROM provision is consistent with the statute and reasonably related to the purposes of Title XIX—a question which the court decided correctly. The judgment below should be affirmed on that more limited ground.[17] *See Los Angeles v. Preferred Communications, Inc.*, 476 U.S. —, 90 L.Ed.2d 480 (1986); *Chicago Teachers Union v. Hudson*, 475 U.S. —, 89 L.Ed.2d 232 (1986) (both affirming court of appeals on narrower grounds).

A. California Could Properly Rely on ROM 2572-D Although It was Not Promulgated in a Formal Rulemaking Proceeding

HHS administers both the Medicaid and the Medicare programs by means of a multitude of informally promulgated instructions and guidelines. The courts have frequently held that these regulatory materials are entitled to deference, so long as they are consistent with the statute and the agency's regulations. *See, e.g., Charter Peachford Hospital, Inc. v. Bowen*, 803 F.2d 1541, 1546-47 (11th Cir. 1986) (Medicare provider manual); *Wisconsin Dept. of Health and Social Services v. Bowen*, 797 F.2d 391, 397-98

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[17] In the court below, no party ever urged that ROM 2572-D is a legislative regulation. Rather, all conceded that the provision is an interpretative guideline. The parties differed only as to its substantive validity. Here, as in the Ninth Circuit, respondents contend only that ROM 2572-D is a valid interpretative guideline upon which California was entitled to rely pursuant to 45 CFR § 201.3(d).

(7th Cir. 1986), *cert. granted*, 55 U.S.L.W. 3493 (U.S., Jan. 20, 1987) (No. 86-648) (HCFA Medicaid action transmittals); *St. Mary's Hospital v. Blue Cross and Blue Shield Ass'n.*, 788 F.2d 888, 890 (2d Cir. 1986) (Medicare provider manual); *Sun Towers, Inc. v. Heckler*, 725 F.2d 315, 325 n.16 (5th Cir.), *cert. denied*, 469 U.S. 823 (1984) (same). This Court has specifically sanctioned deference to such interpretations: "[R]ulings, interpretations and opinions . . . do constitute a body of experience and informed judgment to which courts and litigants may properly resort for guidance." *Skidmore v. Swift & Co.*, 323 U.S. 134, 140 (1944).[18]

There are several particularly strong reasons to defer to ROM 2572-D. First, the provision was issued by HCFA,[19] a "principal operating component" of HHS, 42 Fed. Reg. 13262 (Mar. 9, 1977), to which the Secretary has delegated "the authority vested in [him] under Title XIX" of the Act. 42 Fed. Reg. 57352 (Nov. 2, 1977). HCFA "provides operational direction and policy guidance for the nationwide administration" of the Medicaid program. 46 Fed. Reg. 56911 (Nov. 19, 1981). To that end, it has authority to promulgate policy issuances short of formal regulations. *Id.* at 56912 ("Within broad [HHS] policy and guidelines, the Administrator [of HCFA] oversees the establishment of program goals and objectives and the development of

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[18]On occasion, the Secretary has urged the courts to give informally promulgated Medicaid and Medicare regulatory materials even greater deference, citing the extreme complexity of those programs. *See, e.g., Wisconsin Dept. of Health and Social Services v. Bowen, supra*, 797 F.2d at 394-95.

[19]The guideline was actually first promulgated in June, 1977 by the Medical Services Administration. (See n. 21, *infra*). HCFA reissued it two years later. (J.A. 18, 21).

policies, standards and guidelines''). *See also id.* (HCFA's Office of Executive Operations ''coordinates the preparation of manuals and other policy issuances'' . . .); *id.* at 56929 (Bureau of Program Policy, subsequently renamed BERC [48 Fed. Reg. 512, 514-15 (Jan. 5, 1983)] ''reviews existing policy and develops new policy concerning eligibility . . . for the Medicaid program [and] develops regulations and other policy issuance for these areas'').

Second, the ROM provision interprets § 1903(f) of the Act, which delegates to the Secretary the power to set standards as necessary to implement the statute. § 1903 (f)(1)(B)(i). Nowhere did Congress indicate that all of those standards were required to be set out in formally promulgated regulations, or that informally promulgated interpretative regulations were inappropriate. Moreover, both the statute and the Secretary's regulations create an ambiguity by referring to the highest amounts ''ordinarily'' paid to families of the same size under the AFDC program. HCFA acted well within the terms of its authority in issuing guidelines to address the fact that states do not ''ordinarily'' pay AFDC benefits to families of two adults. (See pp. 29-30, *infra*).

Most importantly, the Secretary's own regulations specifically instruct states to look to informally promulgated ''guidelines'' in formulating their state plans. 45 C.F.R. § 201.3(d) (Br. in Opp., App. 2). States must be able to assume that such interpretative materials are valid and binding, unless and until they are repealed or a court declares them invalid. *See Alcaraz v. Block*, 746 F.2d 593, 614 (9th Cir. 1984) (''[A]ll rules are 'binding' on the regulated parties in the sense that they set, for the time, the legal minima of behavioral standards.'') While provisions

found in agency manuals may lack the force of law, the Secretary himself has endowed guidelines governing the content of state plans with particular significance.

Despite 45 CFR § 201.3(d), petitioner contends that the State should not have relied upon the ROM provision although it was published in the CCH Medicare & Medicaid Guide, (1980 Transfer Binder ¶30,392 at 9521), along with a variety of other similar interpretations relating to standards for approval of state plans.[20] He relies upon the foreword to the Regional Office Manual.

The ROM foreword is a particularly unreliable foundation for petitioner's argument. It was signed at an unknown date by the Director of the Bureau of Health Insurance, (Pet.App. 29a), a component of the then Department of Health, Education and Welfare which existed only until early 1977, and which was responsible only for administration of the Medicare, not the Medicaid, program.[21] 33 Fed. Reg. 5834 (April 16, 1968). Assuming that, under BHI's tenure, HEW employees dealing with Medicare questions were in fact instructed not to disclose the contents of the manual to persons outside HEW's regional offices, there is no way of knowing to what use

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[20]The table of contents to the 1980 Transfer Binder lists 21 ROM sections published therein, some with several subparts. Each is introduced by the sentence, "HCFA has issued guidelines reproduced below . . . ." Similarly, the 1979-2 Transfer Binder contains 35 sections of the ROM.

[21]The Medicaid program was administered by the Medical Services Administration. 40 Fed. Reg. 4670 (Jan. 31, 1975). Both components were transferred to HCFA upon HEW's reorganization in 1977, two years before HCFA reissued ROM 2572-D. 42 Fed. Reg. 13262 (March 9, 1977).

the ROM, as a whole, was put after 1977.[22] And, while the foreword's instructions not to disclose the contents of the manual arguably might make sense in the context of the Medicare program, which is not administered by the states and which requires no state plans, those instructions plainly conflict with 45 CFR § 201.3(d) insofar as the manual contains guidelines for Medicaid state plan review.

Indeed, the Secretary's contention that the ROM was for internal use only during the period pertinent to this case, when examined in light of the contents of ROM 2572-D and of the Manual's other published guidelines, is truly remarkable. The published interpretations cover a wide variety of subjects of vital interest to the states: Questions concerning Medicaid eligibility requirements (CCH Medicare and Medicaid Guide, 1980 Transfer Binder ¶30,392); issues regarding state organization and administration of Medicaid programs, (*id.*, ¶s 30,339-30,391; 1979-2 Transfer Binder ¶30,124); federal reimbursement for staffing and training costs, (*id.*, ¶30,125); and permissible limitations on the scope of coverage of various services, (*id.*, ¶29,997; 1980 Transfer Binder ¶s 30,393-30,395), to name but a few. The thrust of the Secretary's argument is that HHS can review state plans and decide whether to approve them on the basis of "secret law" which has not been and may not be disclosed to the states. If the Ninth Circuit

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[22]There is no copy of the foreword in the record. The hearing officer took judicial notice of it without giving prior notice to the parties, without providing respondents a copy, and without giving them an opportunity to take evidence upon the uses of the manual after 1977. This unorthodox procedure explains the lack of a record regarding the means by which certain of the ROM's provisions came to be published in the CCH Medicare and Medicaid Guide.

had so held, that, indeed, would have been a ruling which would merit reversal. In contrast, the Ninth Circuit's holding that California could rely upon the ROM, particularly in view of 45 CFR § 201.3(d), is hardly controversial, much less "revolutionary". (Pet.Br. 19).

Nor does the judgment below conflict with *Schweiker v. Hansen*, 450 U.S. 785 (1981). That case involved a claim that HHS was estopped from requiring a written application for SSI benefits due to its employee's failure to comply with a provision of an internal manual requiring him to advise the plaintiff that she should complete one. This Court there held that the manual did not have the force of law, and thus could not override statutory and regulatory provisions requiring all SSI applications to be in writing. *Id.* at 789. Here, however, 45 CFR § 201.3(d) clearly envisions that, in drafting their Medicaid plans, states may take into account interpretative guidelines promulgated by HCFA pursuant to its delegated authority to administer the Medicaid program. This regulation is binding upon the Secretary, so long as the guideline in question is consistent with the Act and the Secretary's regulations, as ROM 2572-D is. (See Part II(B), *infra*.)[23]

Finally, petitioner asserts here, as he did for the first time in a footnote to his petition for rehearing in the court below, (Reh. Pet. at 9 n.3), that ROM 2572-D was eliminated from a 1980 revision of the ROM and was thereby repealed. As petitioner notes, repeal is a fact, (Pet.Br. at

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[23]A claim based upon an agency's regulations does not raise an issue of estoppel. *See Lyng v. Payne*, 476 U.S. —, 90 L.Ed.2d 921, 931-32 (1986). Petitioner's discussion of that doctrine (Pet.Br. at 38-41) is simply irrelevant.

38), and there is no evidence whatsoever of this "fact" in the record before this Court—indeed, the record is to the contrary. Certainly, Congress was not made aware that ROM 2572-D had been "repealed" in 1980 when it considered the validity of that provision in 1983-84. And HCFA's April, 1983 "Policy Information for All Regions" letter, issued by the Director of the BERC, stated that the ROM provision had *not* been repealed. (Br. in Opp., App. 13-14). "[T]his Court decides cases based on the record before it." *Wygant v. Jackson Bd. of Education*, 476 U.S. —, 90 L.Ed.2d 260, 271 n.5 (1986).

Generally, a "statement of general policy or interpretation of general applicability" such as ROM 2572-D must be repealed through a notice in the Federal Register. 5 U.S.C. § 552(a)(1)(D). *See Cabais v. Egger*, 690 F.2d 234, 238 n.8 (D.C. Cir. 1982); *Anderson v. Butz*, 550 F.2d 459 (9th Cir. 1977); *St. Elizabeth Hosp. v. United States*, 558 F.2d 8 (Ct.Cl. 1977) (all requiring publication of interpretative rules). *Cf. Action on Smoking and Health v. CAB*, 699 F.2d 1209, 1216 (D.C.Cir. 1983) (APA applies to repeal of regulation). At a minimum, notice must be given in a manner calculated to advise those who previously relied upon the regulation that it has been repealed. *See* 5 U.S.C. § 552(a)(1) ("Except to the extent that a person has actual and timely notice of the terms thereof, a person may not in any manner be required to resort to, or be adversely affected by, a matter required to be published in the Federal Register and not so published.")[24] No notice, in the Federal Register or otherwise,

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[24]Given the circumstances of this case and this provision of the FOIA, the court below was clearly correct in its assertion that the original failure to publish ROM 2572-D in the Federal Register did not affect its validity. (Pet.App. 15a)

was ever given regarding repeal of ROM 2572-D. Thus, unless the provision was inconsistent with Title XIX or the Secretary's regulations, California was entitled to base its adult couple MNIL on the formula set forth in ROM 2572-D.

B. ROM 2572-D Is Consistent With § 1903(f) and With HHS' Regulations

Petitioner insists that ROM 2572-D is invalid because it is inconsistent with § 1903(f) and with 42 C.F.R. § 435.1007. He ignores the fact that the giudeline fills a gap in both the statute and the regulation, and is consistent with both.

Section 1903(f)(1)(B)(i) provides: "[T]he applicable income limitation with respect to any family is the amount determined, *in accordance with standards prescribed by the Secretary*, to be *equivalent* to 133⅓ percent of the highest amount which would *ordinarily* be paid to a family *of the same size*" under the AFDC program. (Pet. App. 46a) (emphasis added). Petitioner contends that the meaning of this provision is self-explanatory. (Pet.Br. at 19). But Congress evidently did not think so: "Congress itself must have appreciated that the meaning of the statutory term was not self-evident, or it would not have given the Secretary the power to prescribe standards." *Batterton v. Francis*, 432 U.S. 416, 428 (1977). As the Court of Appeals noted, this provision does not contemplate "a mathematical procedure," but allows latitude for the Secretary to develop standards for "equivalent" MNILs. (Pet. App. 7a). *See also Schweiker v. Gray Panthers*, 453 U.S. 34, 43 (1981) (when Congress used language of delegation such as that in § 1903(f), it "con-

ferred on the Secretary exceptionally broad authority to prescribe standards" implementing the Act).

Petitioner concedes that Congress' delegation to set standards was designed to address "certain situations . . . in which a MNIL must be determined for a medically needy family for which the state's AFDC plan may have no counterpart . . . ." (Pet.Br. at 28).[25] As HCFA recognized in ROM 2572-D, in setting MNILS for adult couples, states are faced with precisely such a situation. Section 1903(f) directs states to base their MNILs upon "the highest amount which would *ordinarily* be paid to a family of the same size" under the states' AFDC plans. However, states do not ordinarily pay AFDC grants to families of two adults; a state's AFDC payment level for a family of two is ordinarily based upon the needs of one adult and one child. *See* 42 U.S.C. § 606(b) (AFDC defined as "money payments with respect to a dependent child or dependent children"). Nor does the Secretary's regulation resolve this ambiguity, despite his insistence to the contrary: Rather, it simply repeats the statutory formula. 42 CFR § 435.1007(a)(1). *See also* 42 CFR § 435.811(c) (referring to the "highest money payment that ordinarily

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[25]Referring to § 1903(f)(1)(B)(ii), which independently authorizes the Secretary to make "adjustments", and § 1903(f)(3), which itself creates an exception to mathematical parity, petitioner argues that these situations are all "specified by statute." (Pet.Br. at 28). He does not explain the reason for the separate delegation to prescribe standards contained in § 1903(f)(1)(B)(i), for good reason: Far from providing "compelling support" for his position, (Pet.Br. at 23), the legislative history is silent as to the purpose of that delegation, and thus in no way detracts from the broad authority granted to him under the terms of the statute itself.

would be made in the State AFDC program to a . . . family of comparable size").

In ROM 2572-D, pursuant to the authority delegated to it by the Secretary (pp. 22-23, *supra*), HCFA recognized that, given the differing needs of a family consisting of two adults compared to those of a parent and child, an aged and disabled medically needy adult couple is not a "family of the same size" as an AFDC-linked family of two. HCFA's guideline resolved the ambiguity in the statute and the regulation by permitting the states "to effectively acknowledge the greater maintenance needs of an adult as opposed to those of a child" through adult couple MNILs. The guideline, moreover, remained true to Congress' intent in enacting § 1903(f): The ROM's formula is "firmly linked" to the AFDC grant levels, rather than to the higher SSI/SSP grant amounts paid to the categorically needy. (Pet.Br. at 24).

Thus, neither the language of the statute nor its legislative history lends support to petitioner's contention that ROM 2572-D was void *ab initio*. In any event, if there were any doubts which may have existed concerning the validity of the guideline prior to 1984, Congress approved HCFA's interpretation when it enacted the DEFRA moratorium. The House explicitly found, (Br. in Opp., App. 19), and the Conference Committee implicitly assumed that the policy set out in ROM 2572-D was "sound." See pp. 15-16, *supra*. The Conference Committee differed with the House only in its solution to the problem created by TEFRA: The House would have permanently "relax[ed] the single standard requirement only in the limited circumstance" in which a state adopts an adult couple MNIL in excess of 133⅓% of the AFDC grant for two

(App. 20); the Conference Committee refused permanently to "relax the single standard requirement" in this limited respect, but rather proposed a temporary moratorium, during which states are free to adopt a variety of "less restrictive" standards and methodologies, including adult couple MNILs such as California's.[26] Where, as here, Congress " 'has ratified [an administrative construction] with positive legislation,' we cannot but deem that construction virtually conclusive." *Commodity Futures Trading Comm'n. v. Schor*, 478 U.S. —, 92 L.Ed.2d 675, 690 (1986).

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted,

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July, 1987

[26] In his reply to the brief in opposition, petitioner attempts to refute respondents' argument by relying upon post-DEFRA legislative history. S.Rep. 99-520, *supra* (Pet.Rep.Br. at 8, n.3). That committee report, which postdates the decision of the court below by nearly eight months, neither repudiates that decision nor disapproves ROM 2572-D's interpretation of § 1903(f). And a more recent committee report reaffirms that, under the moratorium, "a State plan or policy could establish less restrictive medically needy income levels for an SSI-related elderly couple than is allowed to [a] two-person AFDC-related household. H.R. Rep. 100-85, *supra*, at 25.

APPENDIX A

42 CFR § 435.814 (1980) provided, in relevant part:

Medically needy income standard for two persons.

(a) Except as provided in paragraphs (b) and (c) of this section, the agency must use an income standard to determine eligibility for two persons that at least equals the highest of the following amounts:

(1) The amount of the payment standard for a family of two that is generally used to determine eligibility under the State's approved AFDC plan.

(2) The amount of the income standard used to determine eligibility under SSI of a couple in which both spouses apply as aged, blind, or disabled and live in the same household.

(3) If the agency provides Medicaid, under § 435.230, to individuals receiving only optional State supplements, the amount of the highest income standard generally used to determine eligibility for an optional State supplement for couples in which both spouses apply as aged, blind, or disabled and live in the same household.

(b) An agency may use a lower income standard for two persons if—

(1) The income standard used under paragraph (a) of this section exceeds the maximum dollar amount on income allowed for purposes of FFP under § 435.1007; and

(2) The lower income standard at least equals the maximum amount allowed for purposes of FFP.

APPENDIX B

42 CFR § 435.812 (1981) provided, in relevant part:

Medically needy income standards: Reasonableness.

(a) The agency must use a medically needy income standard that is reasonable.

(b) The following medically needy income standards are presumed to be reasonable:

(1) The agency provides one medically needy income standard for all covered medically needy groups. Except as provided in paragraphs (c) and (d) of this section, the standard must at least equal the highest income or payment standard used to determine eligibility in the cash assistance programs (or an optional State supplement, if the agency provides Medicaid under § 435.230) related to the covered medically needy groups.

(2) The agency provides a different medically needy income standard for each covered medically needy group. Except as provided in paragraphs (c) and (d) of this section, the standard for each covered group must at least equal the income or payment standard used to determine eligibility in the cash assistance program (or an optional State supplement, if the agency provides Medicaid under § 435.230) related to that covered medically needy group.

(c) The agency may use a lower medically needy income standard than the standards specified in paragraph (b) of this section if—

(1) The income standard used under paragraph (b) of this section exceeds the maximum dollar amount on income allowed for purposes of FFP under § 435.1007; and

(2) The lower income standard at least equals the maximum amount allowed for purposes of FFP.

No. 86-863

Supreme Court, U.S.
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CLERK

In the Supreme Court of the United States

OCTOBER TERM, 1987

OTIS R. BOWEN, SECRETARY OF HEALTH AND HUMAN SERVICES, PETITIONER

v.

KENNETH KIZER, DIRECTOR OF THE CALIFORNIA DEPARTMENT OF HEALTH SERVICES, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

REPLY BRIEF FOR THE PETITIONER

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In the Supreme Court of the United States

OCTOBER TERM, 1987

No. 86-863

OTIS R. BOWEN, SECRETARY OF HEALTH AND HUMAN SERVICES, PETITIONER

v.

KENNETH KIZER, DIRECTOR OF THE CALIFORNIA DEPARTMENT OF HEALTH SERVICES, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

REPLY BRIEF FOR THE PETITIONER

---

1. Neither respondents nor their supporting amici make any effort to support the principal holding of the court of appeals: that a statement in an unpublished internal agency manual constitutes a "legislative regulation" that binds the agency, even though the statement is contrary to the plain language of the relevant statute and to the agency's own, duly promulgated, rules. Unable to muster any credible defense for the court of appeals' holding, respondents and amici expressly disclaim any reliance upon that holding (see Resp. Br. 21 & n.17; Amici Br. Md., et al. 3 n.2; Amici Br. Calif. Ass'n Pub. Hospitals, et al. 5). Instead, they seek to recast the manual as a "valid guideline" (Resp. Br. 20), and offer a potpourri of arguments in favor of affording this "guideline" some measure of "deference" (Resp. Br. 21). Respondents' arguments, however, collapse just as quickly as does the "legislative regulation" theory of the court of appeals.

a. If the agency manual is not a legislative regulation, then it does not bind the agency. *Schweiker* v. *Hansen*, 450 U.S. 785, 789 (1981) (Social Security Claims Manual "has no legal force, and * * * does not bind the SSA"); see also *Lyng* v. *Payne*, No. 84-1948 (June 17, 1986), slip op. 10-11. And if the manual does not bind the agency, then it can be changed or repealed at any time, so long as the agency's new position is not "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. 706(2)(a); see, *e.g.*, *NLRB* v. *Iron Workers*, 434 U.S. 335, 351 (1978). Here, the Administrator of the Health Care Financing Administration *repudiated* the relevant provision of the regional office manual, explicitly finding that "[t]he ROM section is patently contrary to the statute and was, therefore, invalid from its origination" (Pet. App. 44a). As we have explained (Br. 22-29), this conclusion was plainly correct. The manual contradicted the express language of Section 1903(f) and the Secretary's implementing regulations (42 C.F.R. 435.1007). Thus, the Administrator's decision to repudiate the manual clearly is *not* arbitrary and capricious. If the manual does not bind the Secretary, and if the decision to repudiate the manual was not arbitrary and capricious, then the Administator's decision must be upheld.

Respondents attempt to bolster their contention that the manual is entitled to "deference" by asserting that the manual is consistent with the statute and regulations. Even if this were correct, it asks the wrong question. The decision under review does not endorse the manual; it repudiates the manual. Hence, the proper question is whether the *repudiation* of the manual is consistent with the statute and regulations. We submit that there can be only one possible answer to this question. Even if Section 1903(f) and the implementing regulations contain some latent ambiguity that would conceivably permit the agency to endorse the manual, there can be no question that the

repudiation of the manual, *i.e.*, the Administrator's decision that a family of two is not the same size as a family of three, is a rational interpretation of the statute and the regulations. A decision by an administrative agency adopting a rational interpretation of its own statute is entitled to significant deference, as this Court has repeatedly held. *Young* v. *Community Nutrition Institute*, No. 85-664 (June 17, 1986), slip op. 7; *Aluminum Co.* v. *Central Lincoln Peoples' Utility Dist.*, 467 U.S. 380, 389 (1984); *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-843, 865-866 (1984).[1]

b. In any event, respondents' efforts to discover some ambiguity in the statute do not withstand scrutiny. Respondents claim (Resp. Br. 28) that in Section 1903(f) Congress delegated authority to the Secretary to prescribe standards for determining when families are the "same size." Section 1903(f) does, of course, empower the Secretary to prescribe "standards." But it does not authorize the Secretary to suspend the laws of mathematics by finding that a family of two is the "same size" as a family of three. As our opening brief shows (at 28), the delegation of authority to set standards was directed at determining the *amount* that would ordinarily be payable to a family of the same size under the state's AFDC program, not at determining when families were the same size.

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[1] For this reason, respondents (Resp. Br. 21-24) and amici (Br. Calif. Ass'n Pub. Hospitals 12, 14) are incorrect in stating that the agency manual provision is entitled to judicial deference because courts have deferred to other provisions of other manuals. Our point is not that courts must always disregard interpretations that are set forth in agency manuals. We acknowledge that if the manual provision referred to in this case were the agency's only statement on the issue, if the manual provision were consistent with the statute, if the manual provision were consistent with the duly promulgated regulation, and if the agency had not rejected the manual provision as inconsistent with the statute, then the views expressed in the manual provision would be entitled to some consideration. But none of those predicates exist in this case.

Alternatively, respondents maintain (Br. 23) that the statute "create[s] an ambiguity by referring to the highest amounts 'ordinarily' paid to families of the same size under the AFDC program." But again, the use of the word "ordinarily" merely indicates that the Secretary has some discretion in determining the *amount* of benefits payable to an AFDC family of a given size; it does not suggest that the Secretary may select the level of benefits payable to a family of three in setting the medically needy income level for a family of two. Different AFDC families of the same size may receive different levels of benefits, depending on whether or to what extent they have "special needs." See 45 C.F.R. 233.20(a)(2)(v). Congress included the word "ordinarily" out of recognition that the Secretary would have to select, among a range of possible amounts payable to AFDC families of a given size, the amount that was most commonly or "ordinarily" received.

The legislative history of the 1967 amendments (which added the 133 1/3 percent cap on federal financial participation) supports the Secretary's reading. The provision which was ultimately enacted with modifications was the House provision, and the language of Section 1903(f) originated with the House bill. The Report of the House Committee on Ways and Means explained that (H.R. Rep. 544, 90th Cong., 1st Sess. 119 (1967)):

> The bill contains provisions intended to facilitate the calculations necessary under the limitations set forth above. Included in the amount ordinarily paid to a family under the AFDC program are not only amounts included in the State standard and made available to everyone in the State (such as food, shelter, and clothing), but also additional items which, although made available on a special needs basis, are provided to a major portion of persons receiving aid.

Clearly, Congress delegated to the Secretary authority to establish standards regarding the *amount* that would ordi-

narily be paid under the AFDC program. There is no support in the legislative history for the proposition that Congress granted the Secretary authority to determine that a family of two adults is the *same size* as a family of three.[2]

2. Bereft of any credible argument in support of affirming the judgment below based on Section 1903(f) or the manual provision, respondents place most of their eggs in the DEFRA moratorium basket. As we have explained (Br. 41-47), both the plain language of DEFRA and its legislative history demonstrate that the moratorium was directed exclusively at the Secretary's authority under a section of the Medicaid statute that is not at issue in this case – Section 1902(a)(10)(C)(i)(III) – *not* Section 1903(f). If there were any doubt on this score, it has been resolved by the enactment of a recent statute that retroactively clarifies the DEFRA moratorium in such a way as to establish conclusively that it does not apply to the 133 1/3 percent ceiling.

a. Respondents' DEFRA argument derives almost exclusively from portions of the Report of the House Committee on Energy and Commerce in 1984 that accompanied a proposal to amend Section 1903(f) in a manner that would have permitted states to exceed the 133 1/3 percent cap for families of two adults. Despite respondents'

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[2] There is no merit to respondents' attempt to denigrate the Secretary's position by labeling it a resort to "secret law" (Resp. Br. 25). Quite the contrary. There is nothing "secret" about the sources upon which we rely: the statute and the formal regulation, both of which plainly state that the cap on federal financial participation is 133 1/3 percent of the highest amount that the AFDC program would pay to a family of the *same size*. It is respondents who would have the courts direct the Secretary to approve state plans on the basis of unpublished manual provisions.

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mischaracterization of the House bill as something that was "passed" or "enacted" (Resp. Br. 15 & n.10), the House proposal was *deleted* by the Conference Committee from the final bill that was in fact passed by both houses of Congress, signed by the President and enacted into law (H.R. Conf. Rep. 98-861, 98th Cong., 2d Sess. 1361 (1984); see Pet. Br. 44-45).

b. Subsequent to the filing of our opening brief, Congress amended the DEFRA moratorium. Section 9 of the Medicare and Medicaid Patient and Program Protection Act of 1987, Pub. L. No. 100-93, 101 Stat. 695 sets forth a "clarification" of the Medicaid moratorium provisions of DEFRA, and Section 15 of the new Act (101 Stat. 698) provides that "[t]he amendments made by section 9 of this Act shall apply as though they were originally included in the enactment of section 2373(c) of the Deficit Reduction Act of 1984." Thus, it is the amended statute that constitutes the law in effect at the time of this Court's decision.[3]

The amended moratorium provision expands the coverage of the earlier legislation by referring explicitly to four provisions of the Medicaid statute that were not included in the original moratorium provision: Section 1902(f),[4]

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[3] Under the recent amendment, the ending date of the moratorium remains 18 months after the Secretary submits the required report to Congress. That report was submitted to Congress on August 17, 1987, so the moratorium will expire on February 17, 1989, unless further extended by Congress.

[4] Section 1902(f) is the "209(b) option" discussed in *Schweiker* v. *Gray Panthers*, 453 U.S. 34 (1981), and is altogether distinct from the Section 1903(f) cap on federal financial participation that is at issue in this case. Both the House and Senate reports note that the 1987 amendment clarifies that the "moratorium applies to all States, including those States operating plans pursuant to section 1902(f) of the Social Security Act (relating to special eligibility rules for aged, blind, and disabled individuals receiving Supplemental Security Income)." H.R. Rep. 100-85, 100th Cong., 1st Sess. Pt. 1, at 24 (1987); S. Rep. 100-109, 100th Cong., 1st Sess. 24 (1987).

and clauses (IV), (V), and (VI) of Section 1902(a)(10)(A)(ii). But the amended moratorium provision, like its predecessor, does *not* refer to Section 1903(f). Clearly, if Congress had "intended" the original DEFRA moratorium to cover Section 1903(f), as respondents maintain, it would have so stated in a statute dedicated to clarification of the original scope of the moratorium. Instead, the Senate Report expressly rejects the notion that the moratorium was intended to relax the cap on federal financial participation set forth in Section 1903(f) (S. Rep. 100-109, *supra*, at 24-25) (emphasis added)):

> The provision only intends to permit States to broaden Medicaid eligibility by changing the rules under section 1902(a)(10) and (17) [5] that govern income and resource eligibility of individuals not receiving cash assistance. Medicaid eligibility cannot be broadened by changing other Medicaid requirements. *For example, the moratorium does not eliminate the limits on income and resources of eligible individuals and families under section 1903(f) (including the requirements that the applicable medically needy income level not exceed the amount determined in accordance with standards prescribed by the Secretary to be equivalent to 133 1/3% of the most generous AFDC eligibility standard* * * *. [6]

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[5] Several of the requirements of Section 1902(a)(10), such as the single standard requirement for the medically needy, are also repeated in Section 1902(a)(17).

[6] The House Report (filed almost two months prior to the filing of the Senate Report) states (H.R. Rep. 100-85, *supra*, Pt. 1, at 25) that:

> A State plan or policy could establish less restrictive medically needy income levels for an SSI-related elderly couple than is allowed to two-person AFDC-related household.

This statement confirms the view of the Secretary that under the DEFRA moratorium a State which has adopted a medically needy income level for an AFDC-related family of two may employ a more

3. Respondents' various arguments ultimately devolve to the proposition that, as a matter of social policy, the United States should subsidize California's decision to increase Medicaid benefits to certain families. As we have explained (Pet. Br. 2, 25 n.9), a state's authority to spend its own funds does not include unlimited discretion over the expenditure of federal funds.[7] There would be no dispute if California chose to provide more generous Medicaid benefits to two-adult families and to fund those benefits from the state treasury. As the 1967 House Report observed, Section 1903(f) "does not in any way place a limitation on what a State can do in developing a broad liberal program. It merely sets a limit on Federal sharing and leaves to the States the option to go beyond this, at their own expense" (H.R. Rep. 544), *supra*, at 118). But Congress, in enacting Section 1903(f), has imposed a carefully defined ceiling on the level of federal financial participation. If, as a matter of social and fiscal policy, this ceiling is to be lifted, that determination must also be made by Congress, not by the courts.[8]

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liberal income level for an SSI-related family of two adults. In other words, such a variation between categories of medically needy recipients does not violate the "same standard" requirement of TEFRA during the moratorium (see Pet. Br. 43-44). But the statement does not suggest that a State may set a two-adult income level in excess of the 133 1/3 percent cap.

[7] Amici Md., et al. note (Br. 2) that the federal government's reimbursement of state Medicaid benefits ranges as high as 70% of the total costs of state programs.

[8] See, *e.g.*, Section 4121 of H.R. 3188, 100th Cong., 1st Sess. (introduced by Representative Waxman on Aug. 7, 1987), a provision entitled "Medically Needy Income Levels for Certain 2-Member Couples in California" which, if enacted, would permit California to amend its Medicaid plan in the manner at issue in this case. That provision states:

> For purposes of section 1903(f)(1)(B) of the Social Security Act, for payments made to California on or after July 1, 1983, in the case of a family consisting only of two individuals both of whom are adults and at least one of whom is aged, blind, or disabled, the "highest amount which would ordinarily be paid to a family of the same size" under the State's plan approved under part A of title IV of such Act shall, at California's option, be the amount determined by the State agency to be the amount of the aid which would ordinarily be payable under such plan to a family which consists of one adult and two children and which is without any income or resources. Section 1902(a)(10)(C)(i)(III) of the Social Security Act shall not prevent California from establishing (under the previous sentence) an applicable income limitation for families described in that sentence which is greater than the income limitation applicable to other families, if California has an applicable income limitation under section 1903(f) of such Act which is equal to the maximum applicable income limitation permitted consistent with paragraph (1)(B) of such section for families other than those described in the previous sentence.

For these reasons, and those stated in our opening brief, the judgment of the court of appeals should be reversed.

Respectfully submitted.

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Solicitor General

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No. 86-863 (6)

IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1986

OTIS R. BOWEN,
Secretary of Health and Human Services,

Petitioner,

v.

KENNETH KIZER,
Director of the California Department of Health Services, et al.,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR AMICI CURIAE CALIFORNIA ASSOCIATION OF PUBLIC HOSPITALS AND COUNTY SUPERVISORS ASSOCIATION OF CALIFORNIA IN SUPPORT OF RESPONDENTS' POSITION

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QUESTION PRESENTED

Whether a federal administrative agency is bound by its own policy even if the policy was not issued pursuant to the publication and rule-making requirements of the Administrative Procedure Act, 5 U.S.C. §§ 552 and 553.

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IN THE
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OTIS R. BOWEN,
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BRIEF FOR AMICI CURIAE CALIFORNIA ASSOCIATION OF PUBLIC HOSPITALS AND COUNTY SUPERVISORS ASSOCIATION OF CALIFORNIA IN SUPPORT OF RESPONDENTS' POSITION

INTEREST OF AMICI CURIAE

The California Association of Public Hospitals ("CAPH") is a California non-profit corporation, the members of which are public hospitals owned and operated by counties throughout California. The County Supervisors Association of California ("CSAC") is a California non-profit corporation, the members of which include more than 250 county supervisors throughout California.

CAPH and CSAC have requested and obtained the written consent of the parties to file this Amici Curiae Brief in support of Respondents' position, urging affirmance of the Court of Appeals' decision. The letters containing the written consents are on file with the Clerk of this Court.

CAPH and CSAC have a compelling interest in the proceedings in this matter because the counties their members represent provide a substantial portion of the Medicaid (known as "Medi-Cal" in California) inpatient and outpatient hospital services in California. The eligibility of patients for Medicaid benefits, and the amount of Medicaid payments made to the State of California by the Secretary of Health and Human Services ("Secretary"), are key concerns of CAPH and CSAC since substantial county revenues are derived from treating Medicaid patients.

In this Brief, CAPH and CSAC limit their discussion and argument to the administrative law issue of whether the Secretary and other federal administrative agencies must adhere to their own written policy even if the policy was not published in the Federal Register and was not promulgated pursuant to the rule-making requirements of the Administrative Procedure Act ("APA").

FACTS

The parties to this proceeding have adequately set forth the specific facts of this case. CAPH and CSAC therefore address only those additional facts relating to the administration of the Medicaid program; facts

which are important to the appropriate resolution of the issue in question.

The Secretary administers the Medicare (42 U.S.C. § 1395) and Medicaid programs through the Health Care Financing Administration ("HCFA"). Indeed, the Secretary expressly delegated virtually all of his authority under Title XIX of the Social Security Act, 42 U.S.C. § 1396 ("Medicaid Act"), to the HCFA Administrator in November 1977. 42 Fed. Reg. 57351-57352 (November 2, 1977). Thus, for example, it was the HCFA Administrator, not the Secretary, who published notice in the Federal Register of the planned implementation of the Court of Appeals' decision in this case. *See* 52 Fed. Reg. 6615-6616 (March 4, 1987).

In addition to issuing formal regulations, HCFA has issued a variety of administrative staff manuals and instructions, containing Medicare and Medicaid policies, procedures and interpretations that affect the public. 42 C.F.R. § 401.112 [1986]. These internal operating manuals include various Health Insurance Manuals ("HIMs"), which contain Medicare and Medicaid policy "guidelines" relating to the administration of the Medicare and Medicaid programs. For example, HIM-14, the Medicare Carriers Manual, governs a variety of important Medicare coverage issues.[1] *See Bowen v. Michigan Academy of Family Physicians*, ___ U.S. ___, 106 S.Ct. 2133, 2139, n.6 (1986).

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[1] The HIM provisions are not promulgated pursuant to APA rule-making requirements and are not published in the Federal Register. *See, e.g., Linoz v. Heckler*, 800 F.2d 871, 873-874, n.2 (9th Cir. 1986).

The manual involved in this case is HIM-23, the HCFA Regional Office Manual, which, like other HIMs, is intended for the use of HCFA employees in the daily administration of the Medicare and Medicaid programs. In addition to being the practical source of Medicare and Medicaid policy, the manual provisions are considered to be binding on many of the Secretary's administrative adjudicators. *See* 42 C.F.R. § § 405.860 and 405.1829 [1986] and discussion in *Bowen v. Michigan Academy, supra*, 106 S.Ct. at 2139, n.6, in which this Court refers to the binding nature of HIM-14 on Medicare hearing officers.

Moreover, the Manual guidelines are applied by HCFA as a source of Medicaid policy in reviewing state plan amendments, such as that involved here. 45 C.F.R. § 201.3(d) [1986].

SUMMARY OF ARGUMENT

In his brief, the Secretary confuses the rationale for, and the application of, the following three *different* principles of administrative law: (1) that to have the binding effect of law *on the public*, federal agency policy ordinarily must be published in the Federal Register (5 U.S.C. § 552) and/or promulgated pursuant to the rule-making requirements of the APA (5 U.S.C. § 553); (2) that federal agencies are bound by their own policy even if such policy is not issued pursuant to APA requirements and is more generous than that required by statute or regulations; and (3) that generally speaking, a federal agency may not be equitably estopped by the negligent provision of erroneous information to a member of the public.

The first and third principles are simply not applicable to the facts of this case. Rather, only the second principle applies and controls the resolution of the case. Just as a federal agency must follow its own formally-enacted regulations, so, as a matter of administrative law, must it also follow its own "informally" issued policy.

In short, although a provision in an agency manual may not have the force and effect of law and thus may not generally bind *the public* (or perhaps be a basis for equitable estoppel), the agency is required to abide by the provision so long as it is extant. This principle of administrative law fosters the uniform application of agency policy and helps to provide certainty to the daily administration of government agencies.

ARGUMENT

I. Agency Policy Which Is Issued Without Compliance With The APA May Not Be Binding On The Public; However, The Issuing Agency Is Nevertheless Required To Grant The Benefits Of Such Policy To The Public.

In his Brief, the Secretary discusses the publication and rule-making requirements of the APA, 5 U.S.C. § 552 and 5 U.S.C. § 553, in connection with his argument that he is not bound by informally issued, nonpublished agency policy.[2] (Sec.'s Brief at 27-28.)

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[2] For the reasons discussed below, the Court of Appeals did not have to discuss the Secretary's compliance or lack of compliance with these APA requirements to hold that the Secretary was bound by the Manual provision in question.

The simple but appropriate response to the Secretary's contention is that the APA publication and rule-making requirements are intended to benefit the public, not to give an administrative agency the opportunity to establish unpublished policy which it may disobey at its unbridled discretion.

As this Court stated in *Morton v. Ruiz*, 415 U.S. 199 (1974), the APA was adopted to provide that "administrative policies affecting individual rights and obligations be promulgated pursuant to certain stated procedures so as to avoid the inherently arbitrary nature of unpublished ad hoc determinations." Public input is assured by 5 U.S.C. § 553, which gives interested parties notice of agency action and an opportunity to be heard regarding agency policy-making. *See N.L.R.B. v. Wyman-Gordon Co.*, 394 U.S. 759, 765 (1969).[3]

Agency policy which is not enacted pursuant to the minimum requirements of the APA is not afforded the force and effect of law and is thus not binding on the public. *See, e.g., Morton v. Ruiz, supra*, 415 U.S. at 231-235; and *Linoz v. Heckler, supra*, 800 F.2d 871 (9th Cir. 1986).

While not generally binding on the public, agency policy issued without compliance with the APA nevertheless must be followed by the agency itself, so

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[3] The APA publication requirements, 5 U.S.C. § 552, are intended to give agencies an extra incentive to publish the necessary details about their official activities in the Federal Register since no person may be adversely affected by material required to be published in the Federal Register but not so published. *See Morton v. Ruiz, supra*, 415 U.S. at 233, n. 27.

long as the policy remains in effect. *See, e.g., Vitarelli v. Seaton*, 359 U.S. 535 (1959), where this principle of administrative law was applied to a Department of Interior internal "order," which had not been issued as a formal regulation and *Sangamon Valley Television Corp. v. United States*, 269 F.2d 221, 224-225, n. 8 and 9 (D.C. Cir. 1959), where the principle was applied to a "rule" of the Federal Communications Commission which had not been formally promulgated but which the court found to have been established by the agency's usual practice.

The holdings in these cases emanate from the general administrative law tenet that an agency must be vigorously held to the standards by which it professes its actions to be judged, even though such standards might be generous beyond the requirements that otherwise bind the agency. *See Vitarelli v. Seaton, supra*, 359 U.S. at 546-547, *Frankfurter, J.; and Service v. Dulles*, 354 U.S. 363, 388 (1957).

As stated by Judge Robinson, "this precept is rooted in the concept of fair play and in abhorrence of unjust discrimination, [footnote omitted] and its ambit is not limited to rules attaining the status of formal regulations." *Mass. Fair Share v. Law Enforcement Assistance Admin.*, 758 F.2d 708, 711 (D.C. Cir. 1985).

In fact, as a result of this doctrine, the lower courts have not hesitated to require the Secretary and his agents to follow the Secretary's policy even when the policy was not issued pursuant to APA requirements. *See, e.g., Hall v. Schweiker*, 660 F.2d 116, 119 (5th Cir. 1981) [Secretary required to follow his own Social Security Ruling] and *Home Health Care, Inc. v. Heckler*, 717 F.2d 587, 591-592 (D.C. Cir. 1983) [Secretary's

agent required to follow provisions of informally issued "Intermediary Letter"].

That an internal policy manual may be non-binding on the public (due to the fact it was not published or promulgated pursuant to APA requirements) but binding on the agency which issued it is illustrated by this Court's holding in *Morton v. Ruiz, supra*. There, a provision of the Bureau of Indian Affairs ("BIA") manual which created a disputed eligibility requirement was deemed *not* to be binding on the public because it was *not* issued pursuant to APA rulemaking requirements. 415 U.S. at 231-235.

Nevertheless, the Court cited and relied on another provision of the very same unpublished manual, a provision which required substantive policies such as the eligibility requirement to be issued pursuant to the APA, to conclude that the eligibility requirement had to be issued pursuant to the APA. 415 U.S. at 235. In short, the Court required BIA to adhere to its own internal manual provisions yet held that the internal manual provisions could not adversely affect members of the public.

This Court re-affirmed the continuing vitality of *Morton v. Ruiz* in *United States v. Caceres*, 440 U.S. 741 (1979), a case on which the Secretary ironically relies.

In *Caceres*, the Court held that the failure of an Internal Revenue Service ("IRS") agent to follow IRS electronic surveillance regulations before recording conversations between a taxpayer and an agent did *not* require suppression of the tape recordings *in a criminal prosecution* of the taxpayer accused of bribing an IRS agent. Despite this conclusion, the Court noted that it did not necessarily follow "as a matter of either logic

or law," that an administrative agency has no duty to obey its own internal rules. 440 U.S. at 752, n. 14. Quoting from *Morton v. Ruiz*, the Court stated that where the rights of individuals are affected, it is incumbent upon agencies to follow their own procedures even if such procedures are possibly more rigorous than otherwise would be required. *Id.*

The Court explained its decision not to apply the holding in *Morton v. Ruiz* to the situation in *Caceres* by emphasizing that *Caceres* was a case of criminal prosecution. Thus, unlike *Vitarelli v. Seaton* and other such cases, it did not involve a cause of action for judicial review of administrative agency action under 5 U.S.C. § 706, which empowers a reviewing court to compel, *inter alia*, an agency to follow its own regulations.[4]

The doctrine that an administrative agency must follow its own rules is not limited to procedural rules. It applies with equal force to interpretive rules, *i.e.*, rules which do not have the force of law but represent the agency's view of what the law means.

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[4] In footnote 18 [440 U.S. at 754], the Court in *Caceres* indicated that agencies may not be required, at the risk of invalidation of their action, to follow all of their own rules, citing *American Farm Lines v. Black Ball Freight Service*, 397 U.S. 532, 538 (1970). This unusual conclusion is not applicable here. In *American Farm Lines*, the Court excused strict compliance (thus allowing substantial compliance) with an agency's internal procedural rule in order to afford the agency sufficient discretion to resolve quickly and correctly urgent transportation problems. The Secretary has advanced no urgency or emergency-type excuse for his refusal to abide by the rule in this case.

In this regard, one noted administrative law authority has stated:

> A logical related question is that of the extent to which an agency is bound by its interpretive regulations. Unlike substantive regulations, interpretive regulations do not have the force of law; they represent only the agency's view of what the law means and do not of themselves affect anyone's legal rights and obligations. [Footnote omitted.] But this does not mean that an agency can treat its interpretive regulations as so many paper words. An agency may not be legally bound by interpretive rulings issued in response to requests for advice by interested individuals. A different situation exists when the interpretation is embodied in a formal regulation promulgated under the agency's aegis. The considerations that make nonstatutory procedural regulations binding on the agency apply as well to interpretive regulations. [Footnote omitted.] Here, too, as far as the agency is concerned, there may be legal effect without statutory authority.

Schwartz, *Administrative Law*, Little, Brown & Co. (2d Ed., 1984) 165-66.

In *Justice v. Board of Education*, 351 F. Supp. 1252 (S.D.N.Y. 1972), the court compelled the Secretary of Agriculture to comply with his own interpretive regulation which required him to apply certain criteria concerning reimbursement for school lunches to all schools under the jurisdiction of a school authority. The court did so even though the Department of

Agriculture had decided that the rules applied only to the individual schools in the district that elected to participate. *Cf. Port of Jacksonville v. U.S. Coast Guard*, 788 F.2d 705, 708-709 (11th Cir. 1986), which holds that an agency is bound to follow its own internal interpretive rule only if a member of the public will be substantially prejudiced if the agency is permitted to disavow its rule.[5]

II. To Assure Uniform Application Of Agency Policy And To Avoid Agency Havoc, Agencies Must Be Required To Follow Their Own Rules Even If Such Rules Have Not Been Enacted Pursuant To The APA.

Relying heavily upon Judge Kozinski's dissenting opinion concerning the Secretary's Petition for *En Banc* review by the Court of Appeals, the Secretary contends that requiring agencies to follow their own internal rules will "wreak havoc on federal agencies," by making formally-enacted regulations subject to contradiction, revision or repeal by far less formal pronouncements made by "lower-level employees." This contention misperceives the nature of the Medicare and Medicaid manuals and the rationale for requiring administrative agencies to follow their own rules.[6]

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[5] The State and the intervenors in this action have demonstrated the substantial prejudice which will result to them if the Secretary is permitted to disavow the Manual provision in question.

[6] Most respectfully, regarding the merits of the underlying issue, Judge Kozinski apparently confuses the legal effect of an internal rule on the *public* with the effect on the *agency* which issued it. In

The Manual in question, HIM-23, was adopted by HCFA, the very same agency which has adopted other manuals relating to Medicare and Medicaid. For example, another HIM issued by HCFA is HIM-15-I, known as the Medicare Provider Reimbursement Manual.

The Secretary routinely requests reviewing courts to defer to his interpretations contained in the Provider Reimbursement Manual. In fact, he often argues that such interpretations are binding on a reviewing court. In turn, reviewing courts have recognized that provisions of the Provider Reimbursement Manual are entitled "to be given important significance." *See, e.g., Sun Towers, Inc. v. Heckler*, 725 F.2d 315, 325, n. 16 (5th Cir.), *cert. denied*, 469 U.S. 823 (1984). Indeed, this Court in *Heckler v. Community Health Services of Crawford*, 467 U.S. 51, 64 (1984), recognized that one of the sources of the Secretary's policy with which a private party was *obligated* to familiarize itself was the Provider Reimbursement Manual.

The Secretary should not be permitted in some cases to argue that his Manual provisions essentially bind reviewing courts and affected members of the public while in other cases, such as this case, to disavow such Manual provisions when he retroactively deems them not to state his present interpretation of the law.

Flores v. Bowen, 790 F.2d 740 (9th Cir. 1986), Judge Kozinski correctly determined that an internal agency rule, which was inconsistent with a formal regulation, could not be applied adversely to a *private party*. However, for the reasons discussed throughout this Brief, it does not necessarily follow that benefits recognized by such an internal rule may be ignored by the agency which issued it.

As indicated in the preceding section, the requirement that agencies must follow their own rules is rooted in the concept of fair play and "in abhorrence of unjust discrimination." *Mass. Fair Share v. Law Enforcement Assistance Admin.*, 758 F.2d at 711. Internal agency guidelines such as those contained in the Manuals are intended to provide uniformity and fairness in connection with agency decision-making.

Manual provisions are issued after consideration and review of the issues by the agency charged with implementing the statutory scheme. It is inappropriate, as a policy matter, to have employees at the regional level second guessing whether manual provisions are consistent with statute and regulation. Such individualized determinations will inevitably result in uneven application of the manual provisions, as different employees reach different results regarding the propriety of the manual provisions under the statute.

Those agency officials and employees who administer federal programs on a day-by-day basis will be in a better position to administer important federal programs in a uniform and non-arbitrary fashion if they know they must adhere to their own Manual provisions and other internal guidelines. If agency officials and employees are permitted to ignore these guidelines, ad hoc decision-making will necessarily occur with resulting arbitrariness. *Cf. Reuters Ltd. v. F.C.C.*, 781 F.2d 946, 950-951 (D.C. Cir. 1986), in which the Court indicated that ad hoc departures from agency rules may not be sanctioned because "therein lie the seeds of destruction of the orderliness and predictability which are the hallmark of lawful administrative action."

Knowing that they are required to abide by their internal rules, agencies will take care that such internal guidelines are consistent with the controlling agency statutes and regulations. If the agencies' enabling statute or formal regulations change, the manual provisions and guidelines may be easily revised. If those agency officials and employees who are responsible for the day-by-day administration of a federal program cannot rely on internal rules and guidelines for fear that they may not accurately reflect the agency's current interpretation of the law, either no agency decision-making will result or the decision-making which does result will be non-uniform and arbitrary.

III. Cases Involving Equitable Estoppel Are Not Applicable To This Matter.

The primary case relied upon by the Secretary to support his asserted right to ignore his own internal rules is *Schweiker v. Hansen*, 450 U.S. 785 (1981). (Secretary's Brief at 25-27, 31.) The Secretary's reliance on *Schweiker v. Hansen* is misplaced because that case involved the issue of whether the federal government may be subject to the doctrine of equitable estoppel.

As stated by the Court, the question presented in *Hansen* was whether a government employee's "erroneous statement and neglect of the [Social Security] Claims Manual estop petitioner, the Secretary of Health and Human Services, from denying retroactive benefits to respondent for a period in which she was eligible for benefits but had not filed a written application." *Id.* at 786.

Equitable estoppel is not an issue in this case and thus the rationale for applying or not applying it is not relevant. In *Lyng v. Payne*, ___ U.S. ___, 106 S.Ct. 2333, 2340 (1986), the Court distinguished the equitable estoppel principle from causes of action under 5 U.S.C. § 706, the cause of action in question in this case.

To the extent *Hansen's* rationale is relevant, it must be analyzed in context. In its summary reversal of the lower court, this Court in *Schweiker v. Hansen* stated that the provisions of the Social Security Claims Manual did not bind the Social Security Administration. However, in making this statement, the Court relied upon the holding in *United States v. Caceres*, *supra*. *Schweiker v. Hansen*, *supra*, 450 U.S. at 789-790. As discussed above, *Caceres* confirms the general principle that an administrative agency is required to obey its own rules. As further stated above, the reason the Court did not set aside the agency action in *Caceres* was that the case involved a criminal prosecution rather than an action for judicial review under the APA.

CONCLUSION

Based on the foregoing, the Court is respectfully requested to hold that the Secretary is required to follow his own manual provision in this case, even though such rule was not published and promulgated pursuant to the provisions of the APA. Based on this holding, the Court is requested to affirm the decision

of the United States Court of Appeals for the Ninth Circuit in this matter.

Respectfully submitted,

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July 17, 1987

PROOF OF SERVICE BY MAIL

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I, the undersigned, say: I am and was at all times herein mentioned, a citizen of the United States and a resident of the County of Los Angeles, over the age of eighteen (18) years and not a party to the within action or proceeding; that my business address is 10835 Santa Monica Boulevard, Los Angeles, California 90025; that on July 17, 1987, I served the within *Brief For Amici Curiae The California Association of Public Hospitals and The County Supervisors Association of California in Support of Respondents' Position* in said action or proceeding by depositing 3 true copies thereof, for each addressee, enclosed in a sealed envelope with postage thereon fully prepaid, in the United States mail at Los Angeles, California, addressed as follows:

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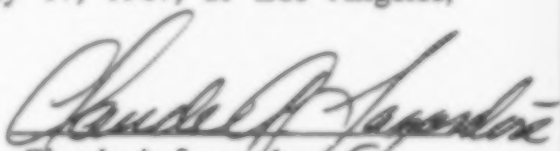

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No. 86-863

IN THE
Supreme Court of the United States
OCTOBER TERM, 1987

OTIS R. BOWEN, Secretary of Health and Human Services,
Petitioner

v.

KENNETH KIZER, Director of the California Department of Health Services, *et al.*,
Respondents

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

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AMICI CURIAE BRIEF IN SUPPORT OF RESPONDENT OF MARYLAND, MINNESOTA, NEBRASKA, NORTH CAROLINA, NORTH DAKOTA, TENNESSEE, VERMONT, AND WASHINGTON

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AMICI CURIAE BRIEF IN SUPPORT OF RESPONDENT OF MARYLAND, MINNESOTA, NEBRASKA, NORTH CAROLINA, NORTH DAKOTA, TENNESSEE, VERMONT, AND WASHINGTON

INTEREST OF THE AMICI CURIAE STATES

The interest of the *amici* States* arises from their responsibility for administering—through an appropriate state agency—their Medicaid state plan and program. Each of the *amici* States, as required by federal statute, provides Medicaid benefits to the "categorically needy"

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* The *amici* States file this *Amici Curiae* Brief pursuant to Supreme Court Rule 36.4 which provides for filing such a brief without consent of the parties.

i.e., AFDC recipients, impoverished pregnant women and young children, and elderly, blind, or disabled SSI recipients. 42 U.S.C. § 1396a(a)(10)(A)(i). *See Atkins v. Rivera*, 106 S. Ct. 2456, 2458 (1986).[1]

Each of the *amici* States also has opted to provide Medicaid coverage to the "medically needy," that is, those who meet the non-financial eligibility requirements for cash assistance but whose income or resources are too high to allow them to qualify for welfare benefits. 42 U.S.C. § 1396a(a)(10)(C). *See Schweiker v. Hogan*, 457 U.S. 569, 581-582 (1982) and *Atkins*, 106 S. Ct. at 2459. These individuals qualify for Medicaid by virtue of having income below the state's established medically needy income level (MNIL) or by incurring medical expenses, thereby "spending down" their "excess" income so as to put them within their state's MNIL. *Atkins*, at 106 S. Ct. 2459.

Amicus State of North Carolina presently provides Medicaid services to approximately 85,000 medically needy recipients at an annual cost of approximately $350 million, of which 69.18 percent is reimbursable to the State from the Petitioner. The *amicus* State of Tennessee presently provides Medicaid services to approximately 27,000 medically needy recipients at an annual estimated cost (for the year July 1, 1986 through June 30, 1987) of approximately $60 million, of which 70.26 percent is reimbursable from the Petitioner. About 13,419 individuals receive medically needy benefits in *amicus* State of North Dakota, at an annual cost in 1986 of almost $70 million. The remaining *amici* states on this brief have

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[1] *Amici* North Carolina, North Dakota, Minnesota, and Nebraska participate in the Medicaid program under the so-called "209(b) option" under which receipt of SSI benefits does not make an elderly, blind or disabled individual automatically eligible for Medicaid. 42 U.S.C. § 1396a(f). *See Schweiker v. Gray Panthers*, 453 U.S. 34 (1981).

comparable financial and administrative commitments to medically needy programs.

Amici have a substantial interest in this Court's sustaining that portion of the decision below regarding the application of the DEFRA moratorium.[2] 781 F.2d 1421, 1429-30 (9th Cir. 1986). Some have attempted to adopt standards for the medically needy which are less restrictive than those used in cash assistance programs, and all have an interest in having the administrative flexibility to do so in the future. In fact, like the Respondent in this case, the *amicus* State of Nebraska has sought to raise its medically needy income level (MNIL) for an adult couple to 133⅓ percent of the AFDC grant level for a family of three, and has been denied approval of such action by Petitioner. *See* Appendix A to this brief at A-1 to A-8.

Amici maintain that the moratorium was intended to provide them, and all other state agencies administering the Medicaid program, with the option to employ more administratively feasible methodologies and standards in their medically needy programs. Petitioner, on the other hand, has taken an extremely restrictive view of the moratorium. In numerous instances Petitioner has refused to approve state plans containing more flexible rules for the medically needy population. Since the moratorium would protect them from loss of federal dollars, *amici* have a substantial interest in insuring that this Court's construction of the moratorium furthers the intent of Congress that States be allowed to establish less restrictive standards and methodologies in their medically needy programs.

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[2] *Amici* do not address or take a position in this brief on the Circuit Court's holding that ROM § 2572-D had the "force and effect of law" and therefore was binding on Petitioner.

SUMMARY OF ARGUMENT

1. The DEFRA moratorium provides state agencies with the option to implement less restrictive and more administratively feasible standards and methodologies for their medically needy population. The moratorium is of limited duration, during which time Congress is to study, assess and ultimately legislate an appropriate approach to the application of cash assistance rules in the medically needy program.

2. The moratorium provides States with necessary flexibility since many cash assistance program rules are administratively cumbersome and ill-suited to the medically needy program.

3. Petitioner's refusal to apply the moratorium in this case is reflective of his overly restrictive view of this statutory provision. Since its passage, Petitioner has interpreted the moratorium provision so narrowly as to nullify Congressional intent.

ARGUMENT

I. CONGRESS PASSED THE DEFRA MORATORIUM AS A TEMPORARY MEASURE DURING WHICH TIME STATES COULD APPLY LESS RESTRICTIVE STANDARDS AND METHODOLOGIES IN THEIR MEDICALLY NEEDY PROGRAMS.

It is necessary to review briefly the legislative history of the Medicaid medically needy program to appreciate the context in which the moratorium was passed in 1984, and thus to gauge accurately its purpose. Prior to 1981, § 1902(a)(10)(C) of the Social Security Act required that eligibility standards for the medically needy be "comparable" to those used for the categorically needy. *See Atkins v. Rivera*, 106 S.Ct. 2456, 2462 (1986). Petitioner and numerous courts understood this language to mean that states were prohibited from using medically

needy criteria which were more restrictive than those used in the cash assistance programs, but were permitted to use more liberal standards. *See, e.g.* 42 C.F.R. §§ 435.401(c)[3], 435.812, 435.840 (1979). *See generally, Caldwell v. Blum*, 621 F.2d 491, 495 (2d Cir. 1980), *cert. den.*, 452 U.S. 909 (1981); *Calkins v. Blum*, 511 F.Supp. 1073, 1091 (N.D.N.Y 1981), *aff'd*, 675 F2d 44 (2d Cir. 1982).

In 1981, through the Omnibus Budget Reconciliation Act (OBRA), Congress amended § (a)(10)(C) to give states additional flexibility in designing their medically needy programs. Pub. L. 97-35, § 2171(a)(3), 95 Stat. 357, 807. During debate, the managers of the bill made clear that Congress did not intend to permit any change in existing comparability rules. 127 Cong. Rec. 18,957 (middle column) (July 31, 1981) (Rep. Dingell); *Id.* at 18,948 (middle column) (Rep. Waxman). *See generally DeJesus v. Perales*, 770 F.2d 316, 325 (2d Cir. 1985).

However, Petitioner interpreted OBRA erroneously by promulgating regulations allowing States to use income and resource criteria for medically needy more restrictive than those for the categorically needy. 46 Fed. Reg. 47,980 (1981). *See Atkins*, 106 S. Ct. at 2462-2463 (1986). Congress' response to Petitioner's OBRA-inspired regulations has been duly noted by this Court:

> Congress disagreed with the Secretary's interpretation. *See, e.g.*, 127 Cong. Rec. H7052 (Oct. 6, 1981) (remarks of Rep. Waxman). This disagreement led to the enactment of the "same methodology" proviso, as part of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), § 137(a)(8), 96 Stat. 378. The House Report explained that TEFRA "makes clear that the Department [of Health and Human Services] had no authority to alter the rules that applied before September 30, 1981, with respect to

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[3] This regulation has not been repealed or amended.

> medically needy income levels, medically needy resource standards, and the methodology for treating medically needy income and resources." H.R. Rep. No. 97-757, pt. 1, p. 13 (1982). The House Report further explained that TEFRA reaffirmed "the financial requirements previously in effect for the medically needy." *Ibid.*

Atkins, 106 S. Ct. at 2463.

The "same methodology" proviso enacted in TEFRA added to the Medicaid statute's existing language the requirement that a state plan include a description of:

> the single standard to be employed in determining income and resource eligibility for all such groups, and the methodology to be employed in determining such eligibility, which shall be the same methodology which would be employed under the supplemental security income program in the case of groups consisting of aged, blind, or disabled individuals . . . and which shall be the same methodology which would be employed under the appropriate State plan . . . to which such group is most closely categorically related in the case of other groups. . . .

Pub. L. No. 97-248, § 137(a)(8)(B), 96 Stat. 324, 378 (1982), *codified at* 42 U.S.C. § 1396a(a)(10)(C)(i)(III).

Unfortunately, Petitioner again misinterpreted Congressional intent behind TEFRA's legislative change. In communications with the state agencies, Petitioner's Health Care Financing Administration (HCFA) insisted that these agencies apply SSI or AFDC income and resource rules to the letter in determining medically needy eligibility.[4] Petitioner required adherence to AFDC and SSI rules regardless of how inappropriate or administratively cumbersome they might be when applied to the medically needy program.

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[4] See, DEFRA Conference Report language, quoted *infra*, p. 8, and "first day of the month" rule discussion, *infra*, pp. 11-13.

Congress' passage of the moratorium in the Deficit Reduction Act of 1984 (DEFRA), therefore, was not a lightly-considered response to a minor administrative flaw in Petitioner's operation of the Medicaid program. Rather, the moratorium was an attempt by a perturbed and somewhat frustrated legislative body to put a temporary halt to Petitioner's misinterpretation of the TEFRA amendment so that it might consider and pass a longer-term constructive response to the problem. Understandably, Congress this time stated its intent in the most unambiguous and mandatory terms:

> (c) (1) The Secretary of Health and Human Services *shall not take any* compliance, disallowance, penalty, or other regulatory action against a State during the moratorium period described in paragraph (2) by reason of such State's plan under Title XIX of the Social Security Act being determined to be in violation of section 1902(a) (10) (C) (i) (III) of such Act *on account of such plan's having a standard or methodology which the Secretary interprets as being less restrictive than the standard or methodology required under such section.*
>
> (2 The moratorium period is the period beginning on the date of the enactment of this Act and *ending 18 months after the date on which the Secretary submits the report required under paragraph (3).*
>
> (3) *The Secretary shall report to the Congress within 12 months* after the date of the enactment of this Act *with respect to the appropriateness, and impact on States and recipients of medical assistance of applying standards and methodologies utilized in cash assistance programs to those recipients of medical assistance who do not receive cash assistance, and any recommendations for changes in such requirements.*

§ 2373(c) (1)-(3) of Pub. L. 98-369, 98th Cong., 2d Sess. (1984). (emphasis added)

Lest there be misinterpretation by Petitioner once again, Congress provided a detailed explanation in its Conference Report as to the intent and reach of the moratorium in DEFRA:

> The conference agreement directs the Secretary not to take any compliance, disallowance, penalty or other regulatory action against a State because a State, in determining eligibility for noncash Medicaid recipients, is using an income or resource standard or methodology that is less restrictive than the applicable cash assistance standard or methodology.

H.R. Rep. No. 861, 98th Cong. 2d Sess. 1366 (1984), *reprinted* at 1984 U.S. Code Cong. & Ad. News 2054.

The Conference Report reviewed the legislative developments (described above) leading to the moratorium. It then provided specific eligibility determination examples to which the moratorium was intended to apply:

> [I]*t is the understanding of the conferees that the Department has implemented* [the TEFRA provision] *in an overly literal fashion, without taking into account the intent of the TEFRA clarification.*
>
> *For example*, the Department is treating certain income and resource rules as "methodology" that must strictly follow SSI or AFDC rules, even though all States with medically needy programs have traditionally been permitted to use less restrictive rules in certain areas. Thus, the Department has taken the position that aged, blind, and disabled medically needy applicants who enter nursing homes and who have marginally excess resources on the first day of the month can not attain Medicaid eligibility during the month, even after their resources are sufficiently depleted by medical costs, because SSI rules only allow eligibility from the first of the month. The Department has also indicated that it may impose quality control sanctions against the States that are using eligibility procedures that were allowed before OBRA and which make sense in the context of the

> medically needy program but which happen to be *less restrictive* than the relevant cash assistance procedures. Similarly, the Department has taken the position that the "single standard" requirement of the TEFRA amendment prohibits States from establishing less restrictive medically needy income levels for single adults and couples because this would result in differences in medically needy income levels among groups of the same family size depending on the relative numbers of adults and children.
>
> *The Department's overly restrictive interpretation of section 137(a)(8) of TEFRA has posed grave administrative problems for the States and threatens to cause great hardship for applicants and beneficiaries.* It is also clear to the conferees that *the strict application of the cash assistance rules to the medically needy and other noncash groups produces unintended, and in some cases, undesirable, consequences.* The conferees have therefore decided to impose a moratorium on the Department's implementation of the TEFRA amendment until the Congress has an opportunity to study and legislate on the matter.

Id. at 1367, 1984 U.S. Code Cong. & Ad. News at 2055. (emphasis added)

Finally, the Conference Report reiterated in unambiguous language the protection afforded state agencies via the moratorium:

> *The conferees intended that, during the moratorium, the Secretary not proceed with the imposition of any sanctions, or otherwise suggest to the States that they must use more restrictive cash assistance standards and methodologies* in their medically needy or other noncash recipient programs. States may use less restrictive standards and methodologies in their noncash programs, although they are still foreclosed from being more restrictive than the relevant cash assistance programs. *It is the expectation of the conferees that the States will be reasonable in establish-*

ing less restrictive variations in the cash assistance methodologies and standards.

Id. at 1368, 1984 U.S. Code Cong. & Ad. News at 2056. (emphasis added)

Thus, in passing the moratorium Congress was instructing Petitioner to halt the present literal interpretation of its TEFRA changes and to allow states flexibility in administering their medically needy programs. *See Atkins v. Rivera*, 106 S. Ct. at 2463 n. 10.

The moratorium prohibition on denying federal matching dollars to states with more flexible medically needy rules was entirely justifiable to Congress since it was to be in effect for a relatively short period of time. Petitioner was directed by Congress to furnish it with a report on the propriety of applying cash assistance rules in the medically needy program. Had Petitioner complied with the time requirements of the moratorium, a report on this issue would have been submitted to Congress by July 18, 1985, and the moratorium would have expired 18 months later, January 18, 1987. Given this limited period of time and given the ongoing misinterpretations of prior legislation by Petitioner, it is not at all difficult to understand Congress' broad mandate in the DEFRA moratorium.

II. THE MORATORIUM PROVIDES STATES WITH NECESSARY FLEXIBILITY SINCE MANY CASH ASSISTANCE PROGRAM RULES ARE ADMINISTRATIVELY CUMBERSOME AND ILL-SUITED TO THE MEDICALLY-NEEDY PROGRAM

Congress passed the DEFRA moratorium because it understood that Petitioner's erroneous interpretation of TEFRA's "same methodology" language was forcing State agencies to use cash assistance rules that simply do not make sense when applied to the medically needy program. In 1985, the American Public Welfare Association issued an interim report prepared by the State Medi-

caid Directors Association's Eligibility Technical Advisory Group, which corroborated Congress' concerns.[5] The report presented the results of a survey of the States.[6] In its Executive Summary, the report states:

> The overwhelming conclusions indicate that the direct link between Medicaid and the cash programs result in:
>
> —impoverishment
>
> —increased State and Federal costs
>
> —burdensome administrative practices

State Medicaid Directors Report at Executive Summary (opening page of interim report); App. at A-10.

The following brief review of several cash assistance eligibility practices and their application to the medically needy program, underlines Congress' wisdom in establishing the moratorium.

1. *SSI "First Day of the Month Rule"*

The Supplemental Security Income (SSI) program's "first day of the month" rule is a prime example of a cash assistance policy that plays havoc when applied to the medically needy program. The rule essentially provides that individuals whose resources exceed SSI standards as of the first day of the month must be considered ineligible for SSI cash benefits for the entire month. 20 C.F.R. 416.421(b) as provided at 51 Fed. Reg. 13,493

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[5] "State Medicaid Directors Report to Congress on Medicaid Eligibility Issues," prepared by the State Medicaid Director's Association of the American Public Welfare Association. [Hereinafter cited and referred to as "State Medicaid Directors Report"]. Relevant excerpts from the report are set out in the Appendix, A-9 to A-17.

[6] State Medicaid Directors Report at 7; App. at A-12. The report states that a total of 39 states responded to the Association's survey, either by completing questionnaires or by telephone response.

(April 21, 1986). The rule may not be unreasonable in the SSI program since clients with excess resources, even if slightly above SSI standards, could use these resources to meet basic maintenance needs of food, clothing and shelter during the month, and then qualify for SSI for the following month.[7] However, a Medicaid applicant or recipient in need of institutional care in a hospital or nursing home can easily incur several thousands of dollars worth of medical costs in a month.

Despite the fact that medical costs can quickly exceed the SSI resource level, the "first day of the month" rule prohibits Medicaid coverage even if the individual's resources at the beginning of the month only slightly exceed the SSI limit.[8] In the survey of states reported in the State Medicaid Directors Report, 76.9 percent of those responding indicated that the "first day of the month" rule was detrimental to the Medicaid client population, and 38.5 percent indicated that the policy was detrimental to state administration of the Medicaid program. State Medicaid Directors Report, *supra* at 7 and 12.[9]

In the DEFRA Conference Report, the "first day of the month" rule was itemized specifically by the conferees as a cash assistance program rule that states should not have to apply in their medically needy programs. *See*

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[7] In 1987 SSI eligibility resource limits are $1800 for an individual and $2700 for a couple. 42 U.S.C. § 1382(a)(3)(A).

[8] For example, an individual with income below the SSI eligibility standard but with $1,850 in liquid resources on the first day of the month—who suffers a medical crisis requiring $10,000 in hospitalization between the 1st and 15th of the month, and $1,500 worth of recooperative nursing home care the latter half of the month—would be ineligible for Medicaid assistance due to the "first day of the month" rule.

[9] App. A-12 and A-14. The report refers to the rule as the "12:01 AM Resource Policy" since exceeding the resource standard as of the first minute of the first day of the month renders the applicant ineligible for the month.

H.R. Rep. No. 861, *supra* at 1367. Despite the inequity of applying the policy in the Medicaid program, and despite the Conference Report language, Petitioner continues to disapprove state plan amendments that do not contain the "first day of the month" requirement.

2. *SSI "In Kind" Income Policies*

Under current SSI requirements, when an elderly, blind or disabled individual is living in the home of a person (such as his adult child) who is providing him with free shelter and food, such support is considered "in kind" income. For SSI eligibility purposes, such in kind income is valued at one-third of the SSI standard which amount is then reduced from the SSI federal benefit rate to determine the recipient's actual SSI grant.[10] 42 U.S.C. § 1382a(a)(2)(A); 20 C.F.R. §§ 416.1130 and .1131. Similarly, if an SSI applicant/recipient is receiving free room and/or board but is not living in the home of the individual providing such in kind support, the "presumed value" of the in-kind income, is deducted from the SSI benefit. 20 C.F.R. §§ 416.1140 and .1141.

These "in kind" income policies may make sense in the SSI program, but they cause inequitable results in the Medicaid program. If an individual's actual income plus his "in kind" income is greater than the SSI standard, he is denied a cash assistance grant. However, under Petitioner's interpretation of TEFRA's "single standard" language, to receive Medicaid the applicant will now be required to "spenddown" (incur medical expenses) his "excess" income to the State's medically needy income level, a standard often below the SSI level. Moreover, in a majority of states with medically needy programs the spenddown amount is calculated on a six-month basis,

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[10] Arguably, TEFRA's "same methodology" provision could allow attribution of one-third of the state's medically needy income level (MNIL), which in most states is lower than the SSI eligibility standard.

i.e., six times the monthly "excess." *See Atkins v. Rivera*, 106 S. Ct. 2456 (1986). Thus, an impoverished medically needy applicant may be faced with a substantial spend-down requirement based, partially, on a calculation of "in kind" income, i.e., income that the applicant cannot spend on medical care.

According to the State Medicaid Directors Report, 79.5 percent of the states responding to its survey agreed that the application of non-liquid in-kind income policies was detrimental to the client population. App. A-13 and A-15. In addition, 71.8 percent maintained that the in-kind income policy was cost detrimental to administration of the Medicaid program. App. A-13. The Report also noted:

> OBRA promulgated policies intended to encourage the utilization of long term home health care as an alternative to having the frail elderly institutionalized in a long term care facility (i.e., nursing home). Requiring states to consider the value of the in-kind income or the one-third reduction serves as a disincentive for families and friends willing to bring the frail elderly into their homes since in many instances the reduction decreases the elderly person's monthly cash by requiring them to incur medical expenses before becoming fully eligible for Medicaid. The cash SSI policy and the purposes and intent of the Medicaid program are clearly incompatible in these areas.[11]

3. *SSI and AFDC Proration Policies*

The State Medicaid Directors Report provides an additional example of cash assistance program rules that make little sense in the Medicaid program. In both the SSI and Aid to Families with Dependent Children (AFDC) programs, eligibility is established as of a specific day in the month. Both programs pro-rate the

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[11] App. A-11 to A-12.

initial cash grant to cover the days from the effective date of eligibility through the end of the month.[12] Again, these policies may not be unreasonable in the cash assistance programs, since an individual applying for cash assistance at some point in a month, presumably has managed without monetary assistance up to that date. However, the same rule being applied in the medically needy program can be devastating since application for Medicaid is often triggered by unexpected, already-incurred medical expenses.

The hypothetical example provided in the State Medicaid Directors Report illustrates the inequity of applying the date specific rule:

> Mr. and Mrs. H and their two children are just managing to make ends meet on his net unemployment insurance of $487 per month. One of the children is rushed to the hospital on June 3 for an emergency appendectomy. Realizing that they no longer have health insurance since Mr. H was laid off, they file for Medicaid on June 8 as soon as the child is out of the hospital. On June 15 they are determined eligible for Medicaid effective on that date. However, coverage is not available for the period from June 3 to June 8, since eligibility had not yet been established, and the H's are faced with a hospital bill of $3,000 which they have no means to pay.[13]

The Medicaid statute specifically requires states to provide retroactive Medicaid coverage for a period of not more than three months prior to the month of application if an individual would have been eligible for such coverage had he or she applied during the retroactive period.

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[12] See 20 C.F.R. § 416.420(b)(1) (SSI rule) and 45 C.F.R. § 206.10(a)(6) (AFDC rule). As pointed out earlier, however, SSI also prohibits eligibility in a month in which an individual's resources are in excess of the resource standard as of the first day of that month.

[13] Addendum A to State Medicaid Directors Report. App. A-16 to A-17.

42 U.S.C. § 1396a(a)(34). Thus in the hypothetical above, the H family may be eligible for Medicaid in March, April and May under the retroactive provision of the statute, but might not be eligible in the beginning of June because state agencies are imposing the "date specific eligibility policy" of the AFDC program. Not surprisingly, 66.7 percent of the 39 states responding to the State Medicaid Directors survey believed that requiring date specific eligibility was detrimental to the client's interests, and 77 percent felt that allowance for establishing eligibility as of the first day of the month of application had no administrative effect or was administratively easier for the state agency. *Id.*, at Addendum B. App. A-17.

4. *SSI's "Bona Fide Effort to Sell" Rule*

Petitioner's "bona fide effort to sell" rule is another graphic example of a cash assistance program policy that is counterproductive when applied to the Medicaid program. SSI rules for the treatment of resources provide that if a property right cannot be liquidated, the property will not be considered a resource of the applicant for eligibility purposes. 20 C.F.R. § 416.1201(a). In turn, Petitioner's Program Operation Manual System (POMS), an SSI policy manual, provides that when a "bona fide effort to sell is made to dispose of a resource and evidence shows there is not a current market for the resource, then the resource shall not be counted . . . ." POMS § 101330.330.

In June, 1985, HHS/HCFA sent out a memorandum describing a decent development in SSI policy affecting Medicaid eligibility. Memorandum 85-4 from Director, BERC to Regional Administrators, Region I-X, "Medicaid Eligibility-Status of SSI Resources Policy Relating to 'Bona Fide Effort to Sell'" (June 3, 1985). App. A-18. The memorandum stated that SSI resource policy, as reflected in a recent Social Security Ruling, does not allow

the "bona fide effort to sell" policy. It therefore concluded that Medicaid eligibility based on "bona fide effort to sell" does not exist.

While the effect of such an interpretation of the "bona fide effort to sell" rule on SSI recipients could be substantial,[14] i.e., loss of SSI cash assistance, the HCFA application of this new SSI methodology had far graver implications for Medicaid nursing home recipients who had been attempting to sell their homes. These elderly, infirm residents were put in the position of becoming ineligible for Medicaid because the homes they were attempting to sell could no longer be treated as exempt resources. Indeed, the policy is counterproductive even from the perspective of cutting program costs. Recipients were required to sell their homes at any price so as not to lose eligibility and thereby face eviction from their nursing home. A far more sensible approach would be for recipients to be allowed a reasonable period in which to sell their home, the proceeds from which could reimburse Petitioner and state agencies for Medicaid nursing home costs expended during the interim period. The "bona fide effort to sell" policy change is a clear example of where the DEFRA moratorium should allow state agencies to apply a more flexible methodology for their medically needy recipients.

5. *Households Containing AFDC- and SSI-Type Members*

Attempting to apply the appropriate AFDC or SSI cash assistance rule can be particularly burdensome for state agencies when the applicant household contains both AFDC- and SSI-type members. For example, a family unit can include a disabled mother, a non-disabled child,

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[14] *Amici*, in this brief, take no position on the accuracy or legality of the above-stated conclusion of the Petitioner as to the application of the "bona fide effort to sell" rule in the SSI or Medicaid programs.

and no father or alternatively, the family may consist of a disabled father, a non-disabled mother, and children. In such cases, the disabled family member is "linked" to the SSI program while the remaining family members are "linked" to the AFDC program. In addition, federal Medicaid regulations require a state agency to allow an individual who would be eligible for Medicaid under more than one category to have his eligibility determined under the category he or she selects (AFDC, SSI, medically needy). 42 C.F.R. § 435.404. Thus, persons who qualify as both SSI-linked and AFDC-linked medically needy must be provided a choice of category under which they wish to have their Medicaid eligibility and benefits computed. *See Calkins v. Blum*, 511 F.Supp. 1073, 1097 (N.D.-N.Y. 1981). The DEFRA moratorium clearly allows States flexibility in administering their medically needy programs by applying a single methodology to such "mixed" households, rather than having to apply different methodologies to different members of the family.

III. PETITIONER'S REFUSAL TO APPLY THE MORATORIUM IN THIS CASE IS REFLECTIVE OF HIS OVERLY RESTRICTIVE VIEW OF THIS STATUTORY PROVISION. SINCE ITS PASSAGE, PETITIONER HAS INTERPRETED THE MORATORIUM PROVISION SO NARROWLY AS TO NULLIFY CONGRESSIONAL INTENT.

In his brief, Petitioner maintains that the DEFRA moratorium does not apply in this action. Rather, Petitioner argues that the 133⅓ percent cap in § 1903(f) [42 U.S.C. § 1396b(f)] operates independently of the "single standard" provision in the medically needy section of the statute. 42 U.S.C. § 1396a(a)(10)(C)(i)(III). Brief for Appellant at 34-35. While *amici* will leave it to Respondent to address the specifics of this argument, it is important for this Court to view Petitioner's position from the perspective of how he has applied the moratorium since its passage. Despite numerous state pro-

posals to adopt standards or methodologies which the moratorium would appear to permit, Petitioner almost invariably rejects such amendments. In essence, Petitioner has rendered the moratorium a nullity, constantly refusing to allow state agencies flexibility in their medically needy programs.

Petitioner has justified this position by relying on a policy decision that the moratorium protects more liberal state medically needy methodologies only if they were "already in existing approved state plans as of the date of the enactment of the [DEFRA] (June 18, 1984)." [15] Of course, given HCFA's strict reading of TEFRA, it would not have approved any state plans with more liberal methodologies at least since TEFRA was enacted. There is no basis whatsoever in the moratorium provision or in the Conference Report to substantiate this restrictive and illogical reading of the moratorium's scope. Indeed, the Conference Report specifically indicates that Petitioner's reading of the statute is in error. The conferees state that they expect "the states *will* be reasonable in establishing less restrictive variations in the cash assistance methodologies and standards." H. Rep. 98-861, *supra*, at 1368. (emphasis added). Clearly, the conferees envisioned states exercising the moratorium's flexibility post-DEFRA.[16]

An example of how Petitioner has used this erroneous interpretation of the moratorium to nullify Congressional mandate can be found in his application of the previously-discussed "first day of the month" rule. *See, supra* at 11-13. In 1982, Petitioner's Health Care Financing Administration (HCFA) began informing States that Medicaid applicants whose resources exceed allowable

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[15] HCFA/HHS Medicaid Action Transmittal No. 85-1 (Jan. 1985), at 4. This transmittal can be found at A-20 to A-26.

[16] The Ninth Circuit, in its decision below, correctly rejected Petitioner's July 18, 1984 moratorium deadline. 781 F.2d at 1430.

state standards as of the first day of the month must be considered ineligible for Medicaid for the entire month.[17] This policy, according to Petitioner, reflected SSI policy at the time.[18] As noted previously, in the DEFRA Conference Report the "first day of the month" rule was itemized specifically by the conferees as one of the cash assistance program rules that states need not apply in their medically needy programs. *Supra* at 8. Nonetheless, despite the Conference Report language, Petitioner continues to disapprove state plan amendments that do not contain the "first day of the month" requirement, and looks to its self-imposed July 18, 1984 deadline as justification for such disapproval.

The absurdity of Petitioner's position can be seen in its dealings with the State of North Carolina. That State's plan amendment was rejected by Petitioner by letter dated October 25, 1985, which noted that the moratorium was not applicable since the more restrictive "first day of the month" rule was in the State's plan as of July 18, 1984 (date of DEFRA's enactment).[19] Petitioner took this position despite the fact that the State initially had *not* instituted the restrictive rule, and only did so in September 1983 because Petitioner specifically so required.[20] In other words, North Carolina had no "first

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[17] *See*, for example, Letter from James J. Pirkle, HCFA, Reg. IV to Barbara Matula, Director, Div. of Medical Assistance, North Carolina (3/28/83). This transmittal is found at App. A-27 to A-28.

[18] *Ibid.*

[19] Letter of Oct. 25, 1985 from HCFA's Acting Administrator, C. McClain Haddow to Phillip Kirk, Secretary of North Carolina Dept. of Human Resources. App. A-29 to A-30.

[20] Memorandum on Behalf of Petitioner in Reconsideration of Disapproval of North Carolina State Plan Amend. 85-5, before the Bureau of Eligibility, Reimbursement and Coverage, Medicaid Program, HCFA, HHS (July 24, 1986). The Respondent State of California is involved in a similar administrative hearing concerning the "first day of the month" rule application in its medically

day of the month" rule until they were told to put one into their plan in 1983. After the passage of the moratorium, it attempted to drop the rule, i.e., to apply more flexible guidelines, and was informed it could not do so because only more flexible rules in place prior to DEFRA are protected by the moratorium.

Petitioner has also used the date of DEFRA's passage as a basis for refusing to approve state plan amendments on issues other than the "first day of the month" rule. For example, rejecting the State of Michigan's proposal to apply "deeming of income and resource methodologies which differ from those methodologies in the related cash assistance programs," HCFA notes that such policies were not included in the State's "current approved plan when the moratorium became effective . . ." 51 Fed. Reg. 12646 and 12647 (April 14, 1986). In rejecting the State of Minnesota's proposed state plan amendments, relating to a number of income and resource methodologies, Petitioner, *inter alia*, maintained that the moratorium "applies only to medically needy groups and only to less restrictive provisions which were in already . . . approved State plans as of July 18, 1984 . . ." Letter of Apr. 29, 1985 from Carolyn K. Davis, HCFA Administrator to Leonard W. Levine, Commissioner, Minnesota Dept. of Public Welfare, at 2. App. A-31 to A-33. Similarly, Petitioner has denied Washington State's proposal to disregard the cost of health insurance premiums in determining medically needy eligibility, concluding that such disregards are not found in the AFDC and SSI programs, are therefore violative of § 1396a(a)(10)(C)(i)(III)

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needy program. In that action, Petitioner's Administrator at HCFA again refuses to apply the moratorium because he claims that Respondent's pre-DEFRA plan included the rule and, therefore, DEFRA would not apply under Petitioner's restrictive reading of the moratorium application period. 52 Fed. Reg. 164-165 (Jan. 2, 1987).

and are not protected by the moratorium since they are not part of an approved state plan. 52 Fed. Reg. 13133 (April 21, 1987).[21]

In short, despite the clear and broad mandate of the moratorium, Petitioner has repeatedly rejected state plan amendments that would allow greater flexibility in determining eligibility for the medically needy than is applicable to the cash assistance programs.[22] Indeed, in the instance of the "first day of the month" rule, Petitioner has rejected state plan amendments which are precisely those which the DEFRA conferees indicated should be covered by the moratorium.

Like the first day of the month rule, the conference committee also specifically addressed and permitted states to establish adult couple medically needy income levels as Respondent has done in this case. Petitioner's position that the DEFRA moratorium is not applicable to the issue before this Court should be weighed in light of his consistent refusal to apply the moratorium according to its terms and Congressional intent.

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[21] Notably, Petitioner's rejection of another Washington State plan amendment as violative of the "same methodology" requirements of § 1396a(a)(10)(C) has since been reversed by the Ninth Circuit, partially because of the protection afforded by the DEFRA moratorium. *State of Washington v. Bowen*, No. 86-7188 (9th Cir. April 20, 1987), *slip opinion* at 12 and 14. At issue was the State's proposal to use its community property law to determine ownership of income for purposes of determining Medicaid financial eligibility.

[22] *See, also* 51 Fed. Reg. 3512 (Jan. 28, 1986) (Notice of hearing to reconsider Respondent's proposals to disregard court-ordered child or financial support in considering eligibility of medically needy applicant and to apply State's community property rules in determining medically needy eligibility.)

CONCLUSION

The mandate of the DEFRA moratorium is clear. Petitioner's refusal to adhere to the moratorium in this action and in numerous other instances is equally clear. The harmful effect of Petitioner's policy on the state agencies and their medically needy applicants is without dispute. *Amici*, therefore, pray this Court to affirm the Ninth Circuit's decision with regard to the DEFRA moratorium. Finally, in the event that this Court decides contrary to Respondent in this action, it should, nevertheless, recognize and affirm Congress' intent to provide states needed flexibility in structuring and administering their Medicaid programs so as to meet the needs of their medically needy residents.

Respectfully submitted,

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July 13, 1987

APPENDIX

APPENDIX

September 22, 1982

Honorable Richard Schweiker
Secretary of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D. C. 20201

Dear Secretary Schweiker,

The State of Nebraska would like to request a waiver of the Medicaid regulations which deal with the income standards for the medically needy found in 42 CFR 435.811 (c) and 435.1007 (1) and (2). We are requesting that a waiver request of the regulation specifically for the aged, blind, and disabled group be placed on the "Governors' Fast Track".

The regulations on income standards for the medically needy in 42 CFR 435.1007 state that for FFP purposes, the income standard may not exceed 133⅓ percent of the highest money payment that would ordinarily be made under the State's AFDC plan to a family of the same size.

In Nebraska, the AFDC payment standard is $210 per month for a unit size of one and increases $70 per month for each additional unit member. Therefore, the allowable medically needy standard is $283.34 per month for an individual, $375 per month for a couple, plus $75 per month for each additional individual.

If an individual or couple has income above the optional State Supplement standards, their eligibility for Medicaid must then be determined on the medically needy income standard. It has been our experience in Nebraska that the medically needy income standard allowable for FFP purposes does not adequately reflect the

needs of this group of people whether they live independently or in an alternate care facility in the community.

The maximum State Supplement standard for an individual living independently is $369 per month ($229 plus $140 maximum shelter allowance) and for a couple it is $552 per month ($377 plus $175 maximum shelter allowance). The standard for individuals living in alternate care facilities range from $329 to $384 per month depending on the type of facility in which the individual is living. Since most of these people have fixed living expenses which exceed the medically needy income standard, they are faced with a most difficult decision of meeting their basic living needs or paying for their medical needs in order to spenddown to the Medicaid standard. In the group of aged, blind, or disabled are many mentally retarded and mentally ill individuals who when faced with this choice often let their medical needs go which ultimately results in more acute medical problems at a later time.

Example #1

The following example outlines the problems experienced with those people living in alternate care facilities. In this example, the client, has $395 per month total income from Social Security. He lives in a licensed Residential Care Facility. The State Supplement standard is $379 per month. The client is allowed $30 per month for personal needs and he must pay the facility $349 for care.

$395.00	SSA
— 7.50	Unearned Income Disregard
$387.50	Net Income

$379.00	State Supplement Standard
—$387.50	Net Income
0	Budgetary need

$387.50	Net Income
—$283.43	Medical Income Standard
$104.16	Excess Income

This client is not eligible for a State Supplement, therefore, he has $104.16 per month excess income to use on medical expenses in order to spenddown to the medical standard. He still has a fixed cost of $349 to pay to the facility. This leaves him $46 per month for personal needs and medical needs. If he has a need for medication of $50 to $60 per month, it is easy to see that he cannot meet all of his expenses. This example is representative of many, many cases throughout the State.

Example #2

This example outlines the situation for an individual living independently in the community. The client is a disabled widow who receives $375 in Social Security benefits. Her prescription medications run about $200 per month. She pays $125 per month for rent.

$375.00	SSA	$229.00	Standard of Need
— 7.50	Unearned Income Disregard	+$125.00	Actual Rent
$367.50	Net Income	$354.00	Total Needs
$354.00	Total Needs	$367.50	Net Income
		−$283.34	Medical Income Standard
−$367.50	Net Income		
0	Budgetary Need	$ 84.16	Excess Income

The client is not eligible for a State Supplement, therefore, she has $84.16 per month excess income to use on medical expenses in order to spenddown to the medical income standard. The client has a fixed cost of $125 for rent and $84.16 for medical expenses which leaves her only $65.83 per month to spend for food, utilities, transportation, and other necessities of life. It is quite apparent that she cannot pay her living expenses plus her medical obligation receiving $375 SSA, which she cannot supplement by working.

One alternative to the problem would be for the State to increase the AFDC payment standard. This, however, does not seem fiscally responsible under current economic

conditions. It seems unlikely that the State Legislature would approve such an increase.

One option which we feel would help many aged, blind, and disabled individuals like those in the examples given would be to allow the State to use the State Supplement standard if it exceeds the medically needy income standard. In the case outlined in Example 1, the client's excess income would be substantially reduced:

$395.00 SSA	$387.50 Net Income
	−$379.00 State Supplement
− 7.50 Disregard	Standard
$387.50 Net Income	$ 8.50 Excess Income

In Example 2, the excess income would be eliminated:

$375.00 SSA	$354.00 State Supplement Standard
− 7.50 Disregard	−$367.50
$367.50 Net Income	0 Excess Income

The second option would be to allow the State to set the medically needy income standard for an individual based on 133⅓ percent of the AFDC payment standard for a family size of two and the medically needy income standard for a couple based on 133⅓ percent of the AFDC payment standard based on a family size of three. In 42 CFR 435.1007 (a) (2), states that the income standard for an individual may be set at 133⅓ percent of an amount *reasonably related to* the highest money payment which would ordinarily be made under the State's AFDC plan to a family size of two. We have previously received a policy interpretation from the HCFA Kansas City Regional Office that because Nebraska has an AFDC payment standard for unit size of one this reference does not apply.

Please consider our request for a waiver of the regulations in 42 CFR 435.1007 and advise us if one or both of these options is acceptable:

1. Using the State Supplement standard or the medically needy standard (see paragraph 3) to determine

medical assistance eligibility, whichever benefits the client.

2. Allow us to set the medically needy income standard for an individual based on 133⅓ percent of the AFDC payment standard for a family of two and for a couple 133⅓ percent of the AFDC payment standard for a family size of three.

The contact person for this waiver will be Donald E. Gerber, Acting State Director, Nebraska Department of Public Welfare, Box 95026, Lincoln, Nebraska 68509.

Thank you for your consideration of this matter.

With kindest regards,

Sincerely,

CHARLES THONE
Governor

CT:csg

cc: Donald E. Gerber
Acting State Director
Department of Public Welfare

bc: Margaret Hall

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201
16 May 1983

Honorable Robert Kerrey
Governor of Nebraska
Lincoln, Nebraska 68509

Dear Governor Kerrey:

This is in response to a letter of February 3, 1983 to the Secretary of Health and Human Services concerning a waiver request pertaining to 42 CFR 435.811(c) and 435.1007(a)(1) and (2) which establish the Federal financial participation (FFP) levels for Medicaid income standards applicable to the medically needy. You have requested a waiver of these provisions in order to adopt medically needy income standards for aged, blind, and disabled individuals and couples that are higher than those authorized under these provisions. You propose to use either a higher State supplement standard or an AFDC payment standard for a larger family unit than the medically needy unit.

While we appreciate the concerns raised and the reason for the request for a waiver, the regulatory provisions you have requested be waived are required by statutory limitations set forth at section 1903(f) of the Social Security Act. This section provides that FFP in expenditures for services is limited to services provided to recipients whose annual income, after certain deductions, does not exceed 133⅓ percent of the highest benefit payment that would ordinarily be made under the State's AFDC program to a family of the same size without income and resources. The statute currently provides no

authority to waive this section 1903 provision as you have requested. Accordingly, we must deny your request for a waiver of 42 CFR 435.811(c) and 435.1007(a)(1) and (2).

We cannot approve for FFP purposes use of Nebraska's current State supplement standard as the medically needy income standard since it would exceed the limit specified in section 1903(f) of the Act and in 42 CFR 435.811(c) and 435.1007. These provisions also prohibit us from approving your request to base your medically needy couple standard on the AFDC payment level for a family of three, since they provide that for FFP purposes the standard for couples cannot exceed 133⅓ percent of the amount the State's AFDC plan would pay to a family of the same size without income and resources. The statute and regulations do, however, permit for FFP purposes the medically needy standard for individuals to be up to 133⅓ percent of an amount reasonably related to the highest amount which would ordinarily be payable under the State's AFDC plan to a family of two persons without income and resources. Therefore, you may wish to submit to the regional office a State plan amendment which revises the standard for individuals.

It should also be noted that in developing medically needy income levels, section 1902(a)(10)(C)(i)(III) of the Act, as added by section 137(b)(8) of the Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248) requires that a single standard be used for all medically needy individuals. There is no longer any provision to vary the standard by group. The exception to this provision is that a State which has exercised its option to apply criteria more restrictive than SSI may have a different medically needy income level for aged, blind and disabled, if the State had a medically needy program in effect on January 1, 1972.

We regret any inconvenience the failure to receive a response to Governor Thone's previous letter on this mat-

ter may have caused. However, as your Office was advised by the Office of the Secretary, the letter of September 22, 1982 was not received by the Department and we were not aware of the earlier request until we received the subsequent letter of February 3, 1983.

Sincerely yours,

/s/ Carolyne K. Davis
CAROLYNE K. DAVIS, Ph.D.

A-9

[Excerpts from State Medicaid Directors Report]

THE STATE MEDICAID
DIRECTORS ASSOCIATION
of the American Public Welfare Association
1125 Fifteenth Street, N.W., Washington, D.C. 20005

Suite 300
Telephone: (202) 293-7550

STATE MEDICAID DIRECTORS
REPORT TO CONGRESS ON
MEDICAID ELIGIBILITY ISSUES

Prepared by:

State Medicaid Directors Association's
Eligibility Technical Advisory Group

chaired by
Robert C. Osborne

EXECUTIVE SUMMARY

In the Deficit Reduction Act of 1984 (DEFRA), Congress directed the Secretary of Health and Human Services not to take any compliance, disallowance, or penalty against the states because states, in determining eligibility for Medicaid, were using income and resource standards or budgeting methodologies that were less restrictive than the methodologies and standards of the Aid to Families with Dependent Children (AFDC) and the Supplemental Security Income (SSI) Programs. The statute directed the Secretary to submit a report to Congress within twelve months of the enactment of DEFRA. The report must describe the impact of requiring the same budgeting methodologies of the SSI and AFDC programs on the Medicaid program.

To ensure that Congress is also made aware of the states' position, the State Medicaid Directors surveyed all states. The overwhelming conclusions indicate that the direct link between Medicaid and the cash programs results in:

—impoverishment

—increased State and Federal costs

—burdensome administrative practices.

As a result, the State Medicaid Directors are submitting this interim report to Congress which represents the states' position regarding this direct link. The report includes several examples that graphically illustrate the result of imposing these cash methodologies on states' Medicaid programs. In addition, a second states' report will offer specific alternatives to correct the deficiencies in the Medicaid eligibility process.

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[Page 6]

One-Third Reduction

In the SSI program, recipients residing in the household of another have their Federal SSI benefit rate reduced by one-third. This same policy applied in the Medicaid program would require that the income eligibility standard be reduced by one-third for persons living in the household of another.

> In another hypothetical example, Mr. R, who is a Medicaid recipient in the State of Minnesota, resides with his son and daughter-in-law. This policy would have the following effect on his application for Medicaid. He receives net income of $300 a month. The monthly medically needy income standard in Minnesota is $347. Since Mr. R is residing with his family, the state's medically needy income standard for him would be two-thirds of $347 or approximately $233 per month. In order for Mr. R to be eligible for Medicaid, he must incur medical expenses equal to the difference between his income, $300, and the two-thirds standard, $233 per month. Therefore, he has to incur medical expenses in the amount of $67 per month before he is eligible for Medicaid. This ⅓ reduction policy appears to be in conflict with the requirements at Section 1902(a)(10) of the Social Security Act, relating to a "single income standard'.

POLICY CONFLICT WITH OBRA

OBRA promulgated policies intended to encourage the utilization of long term home health care as an alternative to having the frail elderly institutionalized in a long term care facility (i.e., nursing home). Requiring states to consider the value of the in-kind income or the one-third reduction serves as a disincentive for families and friends willing to bring the frail elderly into their homes since in many instances the value of the in-kind income or the

one-third reduction decreases the elderly person's monthly cash by requiring them to incur medical expenses before becoming fully eligible for Medicaid. The cash SSI policy and the purposes and intent of the Medicaid program are clearly incompatible in these areas.

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IV. QUESTIONNAIRE AND RESULTS

In order to collect data necessary to complete its report to Congress, HCFA requested assistance from the Eligibility—Technical Advisory Group (E-TAG), an advisory group comprised of Medicaid eligibility experts from ten states. The E-TAG collected information on the effects of some of the cash policies on Medicaid applicants and recipients. States were asked to complete a questionnaire consisting of nine current cash assistance policies which states are finding difficult to apply in the Medicaid program, as required by HCFA. The questionnaire also contained nine alternative policy provisions upon which states were asked to comment. (The alternative policies will be explained in the states' final report to Congress.) (Responses were received from thirty-nine states.* Although all states did not respond, the variance in the size of those states replying indicates that the results are representative of the nation as a whole. The table and charts on pages 11 through 13 illustrate some of the results of the questionnaire. Findings in relation to other policy conflicts are included in the addendum.

12:01 AM Resource Policy

As depicted in the table on page 11, 76.9% of the states responding indicate that the current Federal policy of denying Medicaid eligibility for the entire month if there are excess resources as of 12:01 AM on the first day of

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* Completed questionnaires were received from 35 states. Telephone responses were received from 4 other states.

the month is detrimental to the client population. Only 2.6% of the responses indicate that the current policy is helpful.

In addition to the adverse effect on clients, 38.5% of the states responding indicate that this policy is detrimental to state administration of the Medicaid program. While 35.9% of the states report that this policy has no effect, only 20.5% of the respondents reported that this Federal policy is helpful to state administration of the Medicaid program.

In-Kind Income/One-Third Reduction

These two policies are basically very similar. They are both based on the provision of certain needs without cost and relate to income which is not physically available to the client.

[Page 8]

As shown in the table on page 11, 79.5% of the states responding to this issue stated that the current Federal policy on in-kind income is detrimental to the client population and no state indicated that the current Federal policy is helpful to the client population.

In addition, 71.8% of the respondents indicate that the current Federal policy is cost detrimental to administration of the Medicaid program. (Administrative costs are shared by the Federal and State governments.) Conversely, only 2.6% feel that the current policy is helpful.

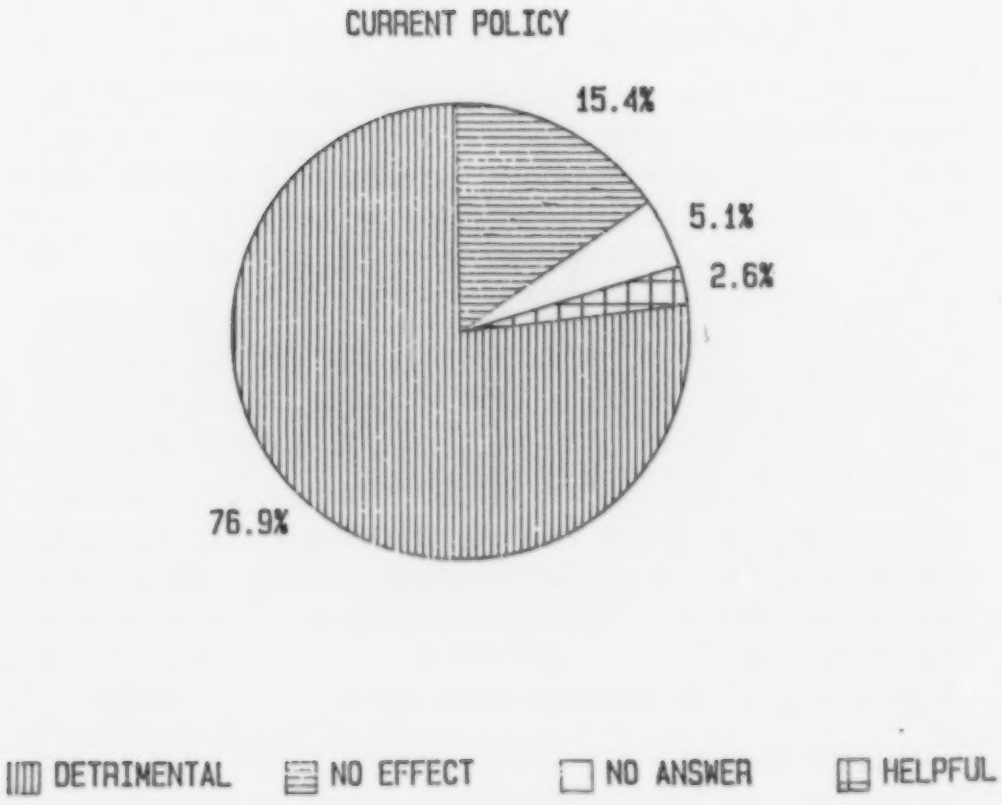
This policy makes it extremely difficult, if not impossible, for the frail elderly to maintain residence in the community. Greater institutionalization, in turn, results in higher Medicaid costs for both the State and Federal governments since institutional care is generally much more expensive than community-based care.

* * * *

[Page 12]

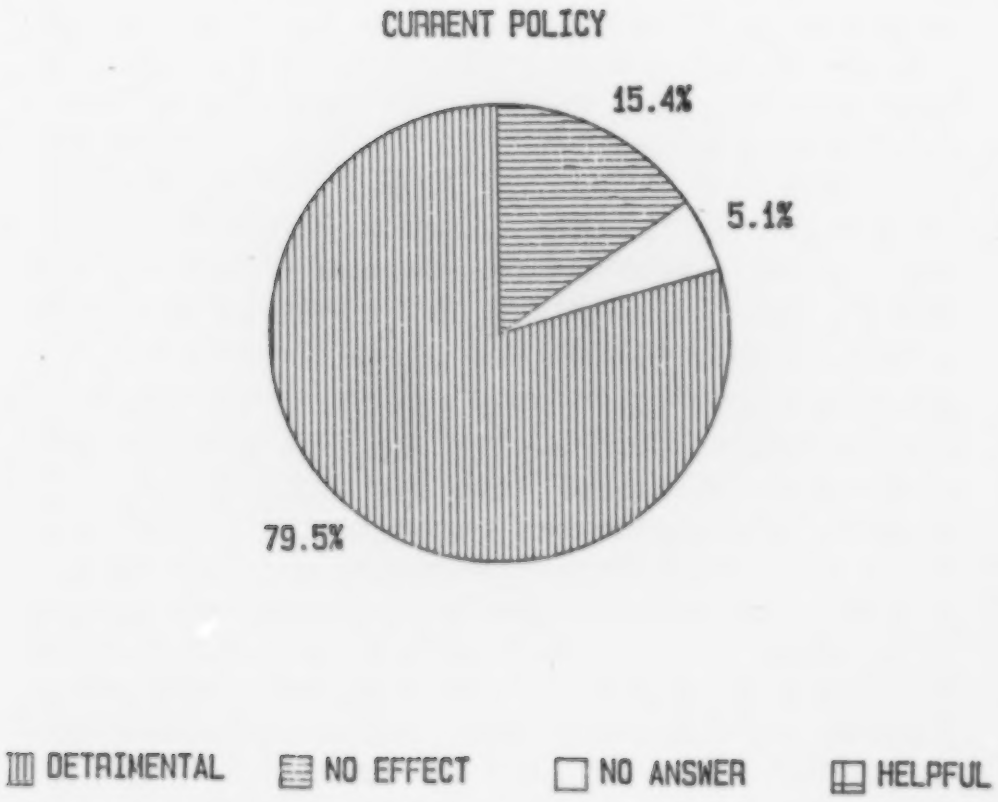
12:01 A.M. RESOURCE POLICY

EFFECT ON CLIENT POPULATION



INKIND INCOME

EFFECT ON CLIENT POPULATION



[Addendum A and portion of Addendum B to State Medicaid Directors Report]

ADDENDUM

Responses to the questionnaires from the states on other policy issues serve to further illustrate the inconsistencies between the cash assistance programs and the Medicaid program.

Date Specific Eligibility

In both the SSI and the AFDC programs, eligibility is established as of a specific day in the month. In the SSI program, the effective date is the date the application is filed; in AFDC, it is the date that the family is determined eligible to receive a grant. In both situations, the initial cash grant is pro-rated to cover the days from the effective date of eligibility through the end of the month. Medicaid has always had the option of establishing the effective date of eligibility as the first day of the month in which an application is filed.

Again, the differences in the purposes of the Medicaid program and the cash programs should be obvious. Cash programs are designed to meet basic maintenance costs. A person applying for cash assistance at some point in a month has managed some how prior to that date. In this situation, date specific eligibility is a viable cost savings methodology. On the other hand, persons and families marginally able to keep up with those basic maintenance expenses would be totally devastated by unexpected medical expenses. The application for Medicaid is often triggered by such costs, and is generally made at a point in time after the expense was incurred.

The following hypothetical example illustrates this point. Mr. and Mrs. H and their two children are just managing to make ends meet on his net unemployment insurance of $487 per month. One of the children is rushed to the hospital on June 3 for an emergency appendectomy. Realiz-

ing that they no longer have health insurance since Mr. H was laid off, they file for Medicaid on June 8 as soon as the child is out of the hospital. On June 15 they are determined eligible for Medicaid effective on that date. However, coverage is not available for the period from June 3 to June 8, since eligibility had not yet been established, and the H's are faced with a hospital bill of $3,000 which they have no means to pay.

Under section 1902(a)34 of the Social Security Act, states must provide Medicaid for a period of not more than three months prior to the month of application if the person was eligible in that period. Thus, the H family may be eligible for Medicaid in March, April and May under the retroactive provisions of the Medicaid program, but would not be eligible in the beginning of June because the states must impose the "date specific eligibility policy" of the AFDC program.

Of the 39 states responding to this policy area, 66.7% felt that requiring date specific eligibility was detrimental to the interests of the client, and 77% felt that establishing eligibility as of the first of the month either has no administrative effect, or is administratively easier for a state agency.

* * * *

DEPARTMENT OF HEALTH & HUMAN SERVICES

Memorandum

Date Jun. 3, 1985

From Director
Bureau of Eligibility, Reimbursement and Coverage

Subject Medicaid Eligibility—Status of SSI Resource Policy Relating to "Bona Fide Effort to Sell"—POLICY INFORMATION FOR ALL REGIONS AND STATES EM 6-85-1

To Regional Administrators
Regions I-X
Attn: Policy and Technical Assistance Branch
Division of Program Operations

The following item concerns a recent development in SSI policy which affects Medicaid eligibility.

SSI instructions relating to "bona fide effort to sell" contained in the Social Security Administration (SSA) Program Operations Manual System (POMS) at SI 01130.330 appear to permit a blanket exclusion for an asset that is not salable at the asking price or original current market value. To the extent the instruction would authorize this treatment of resources, the POMS provision is not a correct reflection of SSI resource policy. SSI resource policy on this subject is reflected in Social Security Administration Ruling (SSR 83-30a) under which there is no "bona fide effort to sell" policy in SSI that would create such a blanket exclusion of resources. As such, any State policy which extends Medicaid eligibility on the basis of a "bona effort to sell" policy which provides for a blanket exclusion from resources of an asset which is not salable at the asking price or original current market value would be more liberal than SSI policy.

In other words, Medicaid eligibility can no longer be extended to individuals who have excess resources and who are making a bona fide effort to sell. Medicaid eligibility based on "bona fide effort to sell" does not exist. Individuals who have excess resources are ineligible for Medicaid.

In general, section 1902(a)(10)(A) of the Act applicable to the categorically needy and section 1902(a)(10)(C) applicable to the medically needy do not permit States to apply eligibility criteria more liberal than the eligibility criteria applied under the SSI program. Additionally, section 1902(f) and 42 C.F.R. 435.121 (which relates only to 209(b) States) permits States to be more restrictive but not more liberal than SSI.

As this represents a clarification of policy, States which require a change in policy must implement such a change by the first day of the month following the 30th day from the date of the memorandum.

/s/ Henry R. Desmarais
HENRY R. DESMARAIS, M.D.

MEDICAID
Action Transmittal

Department of Health and Human Services
Health Care Financing Administration

Transmittal No. 85-1

Date January 1985

TO:

STATE AGENCIES ADMINISTERING MEDICAL ASSISTANCE PROGRAMS

SUBJECT:

HCFA's Interpretation of the Medicaid Moratorium Provisions of Section 2373(c) of the Deficit Reduction Act

STATUTORY REFERENCES:

Section 2373(c) of Public Law 98-369 (the Deficit Reduction Act of 1984) and Section 1902(a)(10)(C)(i)(III) of the Social Security Act.

ATTACHMENTS:

Text of Section 2373(c) of Public Law 98-369.

PURPOSE:

The purpose of this transmittal is to inform Medicaid State Agencies of the provisions of Section 2373(c) of the Deficit Reduction Act of 1984 (DRA) and to provide instructions on HCFA's interpretation of its implementation.

BACKGROUND:

Prior to the Omnibus Budget Reconciliation Act of 1981 (OBRA), States were required to follow the methodologies and standards used in the cash assistance programs for determining the financial eligibil-

ity for both the categorically needy and the medically needy with certain specified exceptions. With the enactment of the OBRA (P.L. 97-35), the Medicaid statute of section 1902(a)(10)(C) of the Social Security Act (the Act), as implemented by regulations which were effective on October 1, 1981, permitted States in determining eligibility of medically needy individuals to apply methodologies that could differ from those used in the relevant cash assistance program where the Secretary determined them to be reasonable. Thus, States were permitted to use methodologies which were more or less restrictive than the Aid to Families with Dependent Children or Supplemental Security Income eligibility methodologies in determining eligibility of their medically needy. Under the OBRA provisions, States were required to submit amendments to their title XIX State plans where they wished to apply Medicaid requirements that differed from those of the cash assistance programs.

With the enactment of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) on September 3, 1982, the Medicaid statute at section 1902(a)(10)(C) of the Act was again amended. These amendments were effective retroactively to the effective date of the OBRA changes. Under the TEFRA (P.L. 97-248) provisions, in determining eligibility of medically needy individuals, States were required to use the same methodologies as those used in the cash assistance programs. Thus, subsequent to TEFRA, any State Medicaid plan submitted which contained different (for example, less restrictive) methodologies than those used in the cash assistance programs should have been disapproved. Additionally, where States were using less restrictive methodologies or standards, compliance proceedings or disallowance could have been initiated.

On July 18, 1984 the DRA was enacted. Section 2373(c) of DRA contained provisions which imposed a moratorium on certain HHS actions arising from States' use of certain standards or methodologies in their medically needy programs. See below for a discussion of these provisions of the DRA.

PROVISIONS OF SECTION 2373(c) OF DRA:

Section 1902(a)(10)(C)(i)(III) of the Act requires that in determining Medicaid eligibility States must apply the same income and resource methodologies as are used in the cash assistance programs and utilize a single income and resource standard. Under section 2373(c) of the DRA the Secretary is prohibited from taking any sanctions (such as compliance, disallowances, penalties, or other regulatory action) against States during a specified moratorium period (see following section on moratorium period) where the States' approved Medicaid plans contain less restrictive income or resource methodologies or standards than would otherwise be prohibited under section 1902(a)(10)(C)(i)(III). The moratorium on these sanctions applies only where the existing approved State plan is or would be in violation of the provisions of section 1902(a)(10)(C)(i)(III) of the Act by reason of the application in the Medicaid program of less restrictive income or resource methodologies or standards than are required under that section of the Act.

MORATORIUM PERIOD:

The moratorium period extends from the date of enactment of the DRA (July 18, 1984) until 18 months after the date on which the Secretary submits a report to Congress with respect to the application of less restrictive cash assistance program in-

come or resource methodologies and standards in the Medicaid program. This report is to be submitted to Congress within 12 months from the date of enactment of the DRA. States will be informed of the specific termination date of the moratorium period following the submittal of the report.

IMPLEMENTATION OF THE MORATORIUM PROVISIONS:

During the moratorium period referred to above, compliance, disallowance, or other regulatory actions will not be taken against a State by HCFA, but only with respect to less restrictive provisions covered by the moratorium and contained in the State's existing approved Medicaid plan. Furthermore, the Medicaid statute at section 1902(a)(10)(C)(i)(III) of the Act was not revised by the DRA. Therefore, subsequent to the DRA, any pending or new submitted State plan amendments, which contain less restrictive provisions which are still prohibited under section 1902(a)(10)(C) of the Social Security Act, will not be approved.

The less restrictive methodologies or standards permitted under the moratorium may apply only to individuals covered under section 1902(a)(10)(C) of the Act (i.e., the medically needy). Thus, the less restrictive provisions covered under the moratorium do not apply to categorically needy individuals covered under section 1902(a)(10)(A) of the Act.

LESS RESTRICTIVE METHODOLOGIES AND STANDARDS:

Section 2373(c) refers to those less restrictive methodologies or standards covered by section 1902(a)(10)(C)(i)(III) of the Act. Section 1902(a)(10)(C)(i)(III) of the Act refers to those methodologies and standards used in determining income and re-

source eligibility for medically needy applicants or recipients. Furthermore, the methodologies are those related to the appropriate cash assistance programs. Therefore, only those less restrictive methodologies and standards which have the following characteristics will be permitted under the moratorium:

1. They are used in determining eligibility for the medically needy.

2. They must only be income or resource methodologies and standards. Other types of nonfinancial methodologies or standards are not covered. Thus, for example, a State could not apply more liberal definitions of disability, age, or blindness than used in the SSI program.

3. The methodologies must be less restrictive with respect to a methodology of the cash assistance programs. Thus, a State could not be more liberal in its spend down program in respects which do not have counterparts in cash assistance program eligibility methodologies. For example, a State could not consider, for purposes of spend down, as "incurred expenses for medical care" expenses which would not be recognized as being for medical care.

4. The less restrictive provisions must not violate other sections of Medicaid statute. For example, section 1903(f)(1) of the Act provides Medicaid requirements for Federal financial participation, requiring a limitation on matching related to medically needy individuals' income. Any less restrictive requirements which violate other Medicaid provisions would also not be approvable.

HCFA will determine whether a particular methodology or standard is less restrictive and is otherwise covered within the purview of the moratorium provisions.

STATE PLAN APPROVAL PROCESS:

Only those less restrictive provisions already in existing approved State plans as of the date of enactment of the DRA (July 18, 1984) will be permitted under the moratorium. No sanctions such as compliance actions will be taken against States with respect to these less restrictive provisions covered by the moratorium and contained in already approved Medicaid State plan preprint pages.

States whose preprint contains pages covering provisions covered by the moratorium may wish to revise their Medicaid plan in the future. HCFA does not interpret the moratorium to require us to prospectively approve new plan amendments which in any respect violate the requirements of section 1902 (a) (10) (C) (i) (III) of the Act. If a State wishes to preserve provisions in its State plan which are protected by the moratorium while it is amending other material on a preprint page which contains material protected by the moratorium, it should indicate that it is only seeking approval of the new material and that it wishes to preserve the original approval dates of the provision which are protected by the moratorium. It should retain in its plan (even after the new material is approved), the original preprint pages which were approved and which are protected by the moratorium. These pages should should be appended to the newly approved pages.

IMPACT ON MEDICAID ELIGIBILITY QUALITY CONTROL:

Since the moratorium applies only where the existing approved State plan is or would be in violation of the provisions of section 1902(a) (10) (C) (i) (III) and since Medicaid eligibility quality control

(MEQC) reviews are conducted against the approved State plan, the moratorium will have no effect on MEQC reviews or error rates for past or future periods.

INQUIRIES TO:

Regional Administrators

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing
Administration

Region IV
101 Marietta Tower
Atlanta GA 30323

March 28, 1983

Ms. Barbara Matula, Director
Division of Medical Assistance
410 North Boylan Avenue
Raleigh, North Carolina 27603

Dear Ms. Matula:

We have received your letter, dated February 4, 1983, which outlines the State's review procedures for cases found ineligible due to bank accounts/assets with excess reserve. The information you received on this issue and the information contained in your letter is incorrect.

According to a change in SSI policy, effective April 1, 1982, the amount of a recipient's resources as of the first moment of the first day of the month will be counted for the entire month. The phrase, "resources as of the first moment of the first day of the month," means existing resources on the first day of the month before any additions or deletions have taken place. The State is to follow this policy according to Health Care Financing Administration Transmittal Notice #16-82, dated March 18, 1982, which states, "This SSI resource policy must be used in determining Medicaid eligibility for categorically needy individuals in States which cover all SSI recipients and in 209(B) States if the State's current policy, or policy in effect on January 1, 1972 is more liberal than SSI policy." This policy also applies to medically needy individuals since there is no provision for spending down resources.

Quality Control reviewers should apply the above policy by verifying resources as of the first moment of the first day of the review month and of the prior month. If the amount of the resources exceeds the maximum allowable resources on both days, the case is in error.

If you have any questions, please contact Charles Sessums at (404) 221-2441.

Sincerely yours,

/s/ James J. Pirkle
JAMES J. PIRKLE
Associate Regional Administrator
Division of Financial Operations

DEPARTMENT OF HEALTH & HUMAN SERVICES

The Administrator
Washington, D.C. 20201

Oct. 25, 1985

Mr. Phillip J. Kirk, Jr.
Secretary
North Carolina Department of Human Resources
325 North Salisbury Street
Raleigh, North Carolina 27611

Dear Mr. Kirk:

We have reviewed North Carolina's Medicaid State Plan Amendment (SPA) No. 85-5 and are unable to approve the proposed changes with respect to allowing medically needy individuals to become eligible on the day countable resources are reduced to the allowable resource amount.

Under Federal statute at section 1902(f) of the Social Security Act and implementing regulations at 42 CFR 435.121, States such as North Carolina must use Medicaid eligibility criteria for the aged, blind and disabled, which are no more restrictive than those contained in the State's January 1, 1972 Medicaid State plan, and no more liberal than the requirements of the Supplemental Security Income (SSI) or an optional State supplement program.

Under the SSI program an individual's resources are accounted for as of the first moment of the first day in a month (SSI Program Operations Manual System Section SI 01150.005). If at that point the individual's countable resources are less than or equal to the allowable resource limit, the individual is resource eligible. If, however, the countable resources exceed the resource level, the individual is ineligible and remains so for the rest of the month, regardless of whether the resources are

reduced below the resource level subsequently during the month.

Under SPA 85-5 North Carolina would permit medically needy aged, blind, and disabled individuals with excess countable resources as of the first moment of the first day in the month to become eligible if, during the month, the resources are reduced to the resource limit. Thus, North Carolina under SPA 85-5 would apply a more liberal rule than permitted under the Medicaid statute and regulations cited above.

This proposed SPA is not affected by the moratorium on compliance, disallowance, penalty or other regulatory actions established by section 2373(c) of the Deficit Reduction Act of 1984 (DEFRA). The moratorium permits States to continue to apply more liberal financial eligibility rules than SSI but only with respect to provisions already contained in a State's Medical State Plan as of the enactment of DEFRA on July 18, 1984. As of that date, North Carolina's State plan did not contain a provision such as contained in SPA 85-5.

Based on the above and after consultation with the Secretary as required by 45 CFR 201.3, I am hereby disapproving the subject plan amendment because it is in violation of existing Federal law and regulations. If you are dissatisfied with this determination you may petition for reconsideration of the issue within 60 days after the date of this letter in accordance with the procedure set forth in 45 CFR 201.4.

If you wish to discuss the implications of this disapproval further please contact Mr. Richard L. Morris, Associate Regional Administrator, Suite 701, 101 Marietta Tower, Atlanta, Georgia 30323.

Sincerely yours,

/s/ C. McClain Haddow
C. McCLAIN HADDOW
Acting Administrator

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration
The Administrator
Washington, D.C. 20201

Apr. 29, 1985

Mr. Leonard W. Levine
Commissioner
Minnesota Department of Public Welfare
Centennial Office Building
658 Cedar Street
St. Paul, Minnesota 55155

Dear Mr. Levine:

The Health Care Financing Administration has carefully reviewed your proposed title XIX State Plan Amendments (Transmittal Numbers 83-30 and 83-35). These plan amendments provide for a number of financial (income and resource) methodologies to be applied under the Minnesota Medicaid program.

Both plan amendments contain disapprovable provisions which are summarized below and described in greater detail in the attached report. Furthermore, both plan amendments contain approvable portions which are also discussed in the enclosed report.

Generally, the Medicaid statute at section 1902(a)(10)(A) and (C) of the Social Security Act (the Act) requires States to apply the same financial methodologies as are applied in the cash assistance programs (for example, SSI or AFDC) in determining eligibility for Medicaid in their medically needy programs. Under SPAs 83-30 and 83-35 Minnesota proposes to apply a number of income and resource methodologies which are more liberal than the related cash assistance programs. Thus, these amend-

ments violate section 1902(a)(10)(C) of the Act and must be disapproved on that basis.

Section 1902(f) of the Act does permit States, such as Minnesota, to apply financial methodologies which are more restrictive than the methodologies of the cash assistance programs but no more restrictive than those contained in the State's January 1, 1972 Medicaid State plan. Note, under section 1902(f) of the Act a State may not apply methodologies which are more liberal than the cash assistance programs. Under SPAs 83-30 and 83-35 Minnesota proposes to apply a number of income and resource methodologies which are more restrictive than those contained in its January 1, 1972 plan. Thus, these amendments must be disapproved on that basis.

Additionally, section 1902(a)(17) of the Act as implemented in regulations at 42 CFR 435.831 and 435.832 requires States to use a two-step process in determining first, medically needy eligibility and second, post-eligibility application of income to the cost of care for institutionalized individuals. These steps are separate and different. Under SPA 83-30 Minnesota proposes to apply a single step for determining both eligibility and post-eligibility treatment of income for institutionalized individuals Thus, SPA 83-30 violates regulations at 42 CFR 435.831 and 435.832 and must be disapproved on that basis. Furthermore, section 1902(a)(1)(C)(i)(III) of the Act requires that Medicaid eligibility for the medically needy must be determined by the use of a single income standard which can vary as provided by section 1902(a)(17), only with respect to differences in shelter costs between rural and urban areas. Therefore, the single standard cannot vary based on living arrangements, i.e., on institutionalization versus residing in the community. The Minnestota proposal effectively imposes a medically needy income eligibility standard for institutionalized individuals which is different from the medical needy income level used to determine eligibility of individuals residing

in the community. The eligibility standard proposed for institutionalized individuals is derived from the State's institutional payment rate.

You believe the income and resource methodologies proposed in SPAs 83-30 and 83-35 are allowable under section 2373(c) of the Deficit Reduction Act of 1984 (DEFRA). Section 2373(c) of DEFRA imposed a "moratorium" with respect to the application of the provisions of the law requiring the cash assistance methodologies to be applied under medically needy programs. Under the moratorium, less restrictive financial eligibility methodologies may be applied to provisions in the State plan. However, the moratorium applies only to medically needy groups and only to those less restrictive provisions which were in already contained approved State plans as of July 18, 1984, the effective date of DEFRA. Since the proposals contained in Minnesota SPas 83-30 and 83-35 are either not already contained in your currently approved State plan or apply to categorically needy groups, these provisions are not covered by the moratorium. Thus, the moratorium provisions do not apply to Minnesota SPAs 83-30 and 83-35.

Based on the above and after consultation with the Secretary as required by 45 CFR 201.3, I am hereby disapproving those disapprovable provisions of SPA 83-30 as discussed in the attached report and Supplement 2 to Attachment 2.6-A page 2 of SPA 83-35. These provisions of SPA 83-30 and 83-35 are in violation of existing Federal law and regulations. If you are dissatisfied with this determination, you may petition for reconsideration of the issue within 60 days after the date of receipt of this letter in accordance with the procedure set forth in 45 CFR 201.4.

Sincerely yours,

/s/ Carolyne K. Davis
CAROLYNE K. DAVIS, Ph.D.

Enclosure

MOTION FILED
JAN 7 1988

No. 86-863

In The
Supreme Court of the United States
October Term, 1987

Otis R. Bowen, Secretary of Health and Human Services,
Petitioner,

v.

Kenneth Kizer, Director of the California Department of Health Services, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

MOTION TO DISMISS AS MOOT

EVELYN R. FRANK*
Legal Aid Society of
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Attorney for Respondents Barrier, Bierman, Jones and Kwiek

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or call collect (402) 342-2831

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LEGISLATIVE HISTORY

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H.R. 3545, 100th Cong., 1st Sess. (1987) 2

H.R. Rep. 100-495, 100th Cong., 1st Sess. (1987) 2

H.R. Rep. 100-391, 100th Cong., 1st Sess. (1987) 2, 3

This case concerns the validity of an amendment to California's Medicaid plan establishing an adult couple medically needy income level ("MNIL"). That income standard is set at 133 1/3% of the AFDC grant payable to a family of three people without other income or resources. In an administrative proceeding held pursuant to 42 U.S.C. § 1316(a), the Secretary disapproved the amendment, holding that, under § 1903(f) of the Social Security Act, 42 U.S.C. § 1396b(f), the State could not receive federal financial participation for an income standard in excess of 133 ⅓% of the AFDC grant for a family of two. The Ninth Circuit reversed. *Cubanski v. Heckler*, 781 F.2d 1421, *rehearing en banc denied*, 794 F.2d 540 (9th Cir. 1986). This Court granted certiorari. 55 U.S.L.W. 3569 (Feb. 24, 1987). The matter was argued and submitted on November 10, 1987.

In his reply brief in this Court, the Secretary noted that Representative Henry Waxman[1] had introduced a bill which, "if enacted, would permit California to amend its Medicaid plan in the manner at issue in this case." (Petitioner's Reply Brief at 8, n. 8). The bill to which the Secretary referred, § 4121 of H.R. 3188, 100th Cong., 1st Sess. (1987), provided:

> For purposes of section 1903(f)(1)(B) of the Social Security Act, for payments made to California on or after July 1, 1983, in the case of a family consisting only of two individuals both of whom are adults and at least one of whom is aged, blind, or disabled, the "highest amount which would ordinarily be paid to a family of the same size" under the State's [AFDC]

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[1]Representative Waxman is the chairperson of the Subcommittee on Health and the Environment of the House Energy and Commerce Committee. His subcommittee has jurisdiction over the Medicaid program.

> plan . . . shall, at California's option, be the amount determined by the State agency to be the amount of the aid which would ordinarily be payable under such plan to a family which consists of one adult and two children and which is without any income or resources. Section 1902(a)(10)(C)(i)(III) of the Social Security Act shall not prevent California from establishing (under the previous sentence) an applicable income limitation for families described in that sentence which is greater than the income limitation applicable to other families, if California has an applicable income limitation under section 1903(f) of such Act which is equal to the maximum applicable income limitation permitted consistent with paragraph (1)(B) of such section for families other than those described in the previous sentence.

The House of Representatives subsequently enacted this provision as § 4121 of H.R. 3545, the Omnibus Budget Reconciliation Act of 1987. The Committee Report explained that the purpose of the measure was to "clarify that the State of California has had, and continues to have, the option to set its MNIL for an adult couple at 133 ⅓ percent of the amount of the State's AFDC payment standard for a family of three with no income or resources." H.R. Rep. 100-391 100th Cong. 1st Sess. 485 (1987) (Appendix A, hereto, at 2). In the final version of the Omnibus Budget Reconciliation Act, Congress adopted the House provision verbatim. P.L. 100-203, 100th Cong., 1st Sess. (1987), § 4106 Appendix B, hereto). *See also* H.R. Rep. 100-495, 100th Cong., 1st Sess. (1987) (Conference Committee report) (Appendix C hereto).

A decision disapproving a state plan amendment is not self-executing, but is enforced by means of withholding federal financial participation either through an audit disallowance or through a nonconformity decision. *See gen-*

erally New Jersey v. Department of Health and Human Services, 670 F.2d 1262, 1268-1271 (3d Cir. 1981). In this case, Congress has deprived the Secretary's decision of any force or effect by guaranteeing California full federal financial participation for the cost of its adult couple MNIL. The OBRA provision, moreover, has retroactive as well as prospective effect. It applies to "all Federal matching payments made to California on or after July 1, 1983 for services provided to adult medically needy couples," H.R. Rep. 100-391, *supra*, at 485—that is, it is operative back to the date on which the State commenced applying its adult couple MNIL.[2] *Cubanski v. Heckler*, *supra*, 781 F.2d at 1423.

Thus, the Secretary may not disallow any claim for the federal share of California's expenses, past or future, based upon his predecessor's disapproval of the adult couple MNIL. This case is therefore moot, and must be dismissed. *Diffenderfer v. Central Baptist Church*, 404 U.S. 412, 414-15 (1972); *Hall v. Beals*, 396 U.S. 45 (1969).

Respectfully submitted,

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Attorney for Respondents
Barrier, Bierman, Jones
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*Counsel of Record

January 1988

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[2]The committee report reiterates the language of the statute itself, which explicitly states that it applies to "payments made to California on or after July 1, 1983 . . ." (Appendix B).

APPENDIX A

H.R.Rep. 100-391, 100th Cong., 1st Sess. (1987), provided with respect to § 4121 of H.R. 3545:

Sec. 4121.—Medically needy income levels for certain 2-member couples in California

Under current law, States have the option of extending Medicaid coverage to the "medically needy." These are aged, blind, or disabled individuals or adults and dependent children who meet the categorical requirements under the Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI) programs but whose incomes or resources are too high to allow them to qualify for cash assistance benefits. In order to qualify for "medically needy" coverage, an individual must "spend down" by incurring medical expenses until these costs, when applied against the individual's income for the relevant accounting period, reduce that income below the State-established medically needy income level. Any medical expenses incurred after that point, if covered under the State Medicaid plan, would be paid for by Medicaid, until the beginning of a new accounting period, when the individual would have to repeat the "spend-down" process to re-establish coverage.

California has opted to cover the medically needy. In 1983, California adopted a medically needy income level (MNIL) for an adult couple. In accordance with a HCFA Regional Office Manual provision, California set the MNIL at 133⅓ percent of the AFDC cash grant to a family of three with no income. The State submitted a Medicaid plan amendment reflecting this change which HCFA dis-

approved on the grounds that the MNIL could not exceed 133⅓ percent of the AFDC cash grant to a family of two with no income. The State appealed the Secretary's disapproval, and the Ninth Circuit Court of Appeals properly reversed the Secretary, *Cubanski v. Heckler*, 781 F.2d 1421 (9th Cir. 1986). The Supreme court has granted the Secretary's request for *certiorari*.

California's MNIL for an adult couple is currently $825 per month. All but this amount of their monthly income must be used to pay for medical care. The $825 represents the amount these aged and disabled couples are allowed to use to cover their non-medical necessities, such as food, clothing, and shelter. Under HCFA's interpretation, the MNIL would drop to 133⅓ percent of the AFDC payment standard for a family of two with no income or resources, or $667 per month. About 14,600 aged or disabled couples would have to spend an additional $158 per month before receiving any Medicaid coverage. The Committee can see no justification for stripping these couples of the protections to which they are entitled under current law and practice and imposing additional cost-sharing burdens on them.

The Committee amendment would clarify that the State of California has had, and continues to have, the option to set its MNIL for an adult couple at 133⅓ percent of the amount of the State's AFDC payment standard for a family of three with no income or resources. The amendment would apply to all Federal matching payments made to California on or after July 1, 1983, for services provided to adult medically needy couples.

APPENDIX B

Section 4106, P.L. 100-203 (Omnibus Budget Reconciliation Act of 1987), 100th Cong., 1st Sess. (Dec. 22, 1987) provides:

Medically Needy Income Levels For Certain 2-Member Couples in California

For purposes of section 1903(f)(1)(B) of the Social Security Act, for payments made to California on or after July 1, 1983, in the case of a family consisting only of two individuals both of whom are adults and at least one of whom is aged, blind, or disabled, the "highest amount which would ordinarily be paid to a family of the same size" under the State's plan approved under part A of title IV of such Act shall, at California's option, be the amount determined by the State agency to be the amount of the aid which would ordinarily be payable under such plan to a family which consists of one adult and two children and which is without any income or resources. Section 1902(a)(10)(C)(i)(III) of the Social Security Act shall not prevent California from establishing (under the previous sentence) an applicable income limitation for families described in that sentence which is greater than the income limitation applicable to other families, if California has an applicable income limitation under section 1903(f) of such Act which is equal to the maximum applicable income limitation permitted consistent with paragraph (1)(B) of such section for families other than those decribed in the previous sentence.

APPENDIX C

H.R. Rep. 100-495, 100th Cong., 1st Sess. (1987) provides in relevant part:

Medically Needy Income Levels For Certain 2-Member Couples in California (Section 4121 of House Bill)

Present Law

For purposes of Federal matching, medically needy income levels can be no higher than 133 1/3 percent of the State's AFDC cash payment level for a family of the same size without any income or resources. California has based its medically needy income levels for the elderly and disabled on the AFDC payment standard for a family of three.

House Bill

Permits California, for payments made on or after July 1, 1983, to use a specified medically needy income level for families consisting of two adults, at least one of whom is aged, blind, or disabled. This level may not exceed the AFDC payment level for a three person family, consisting of one adult and two children, without any income or resources. The income limitation established for these families may be greater than that applicable for other medically needy families in California.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill.

Effective Date

The provision is effective upon enactment.

No. 86-863

Supreme Court, U.S.
FILED
FEB 12 1988
JOSEPH F. SPANIOL, JR.

In the Supreme Court of the United States

OCTOBER TERM, 1987

OTIS R. BOWEN, SECRETARY OF HEALTH AND HUMAN SERVICES, PETITIONER

v.

KENNETH KIZER, DIRECTOR OF CALIFORNIA DEPARTMENT OF HEALTH SERVICES, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

MEMORANDUM FOR THE PETITIONER SUGGESTING MOOTNESS

CHARLES FRIED
Solicitor General
Department of Justice
Washington, D.C. 20530
(202) 633-2217

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In the Supreme Court of the United States

OCTOBER TERM, 1987

No. 86-863

OTIS R. BOWEN, SECRETARY OF HEALTH AND HUMAN SERVICES, PETITIONER

v.

KENNETH KIZER, DIRECTOR OF CALIFORNIA DEPARTMENT OF HEALTH SERVICES, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

MEMORANDUM FOR THE PETITIONER SUGGESTING MOOTNESS

The Solicitor General, on behalf of the Secretary of Health and Human Services, respectfully suggests that this case is presently moot because of the enactment of Section 4106 of the Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203 (Dec. 22, 1987), and action taken by the Secretary of Health and Human Services pursuant to Section 4106.[1]

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[1] We have reproduced Section 4106 of the Omnibus Budget Reconciliation Act of 1987 as Appendix A to this memorandum (App., *infra*, 1a). The Act is not yet available as a printed public law, paginated as it will appear in the Statutes at Large. We therefore have reproduced Section 4106 as it appears in the House Conference Report on the bill (H.R. Conf. Rep. 100-495, 100th Cong., 1st Sess. (1987)), which is printed in the Congressional Record. See 133 Cong. Rec. H12103, H12146 (daily ed. Dec. 21, 1987). We previously informed the Court of the enactment of Section 4106 by letter to the Clerk dated December 30, 1987, and we appended to that letter copies of the pertinent pages of the House Report (H.R. Rep. 100-391, 100th

1. This case presents the question whether a proposed amendment to California's Medicaid plan is consistent with Section 1903(f)(1)(B)(i) of the Social Security Act, 42 U.S.C. 1396b(f)(1)(B)(i). Section 1903(f)(1)(B)(i) sets the maximum income level for federal financial participation purposes under the "medically needy" Medicaid program at 133⅓% of the highest amount that would ordinarily be paid to a family of the "same size" under the Aid to Families with Dependent Children (AFDC) program in the State. The proposed amendment at issue in this case—California State Plan Amendment (SPA) 83-14—sets the medically needy income level for a family consisting of two adults at 133⅓% of the amount paid to a family of three under California's AFDC program.

Respondent Kizer's predecessor as Director of the California Department of Health Services formally submitted SPA 83-14 to the Health Care Financing Administration (HCFA) in the Department of Health and Human Services in September 1983 (J.A. 22-24). In a final decision rendered on January 30, 1985, the Administrator of HCFA disapproved the proposed amendment on the ground that it sought federal financial participation for one category of California families—adult couples—at levels of income that exceeded the cap imposed by Section 1903(f)(1)(B)(i) (Pet. App. 38a-45a). On petition for review, the court of appeals reversed the Administrator's decision disapproving SPA 83-14 (*id.* at 1a-19a). This Court then granted the Secretary's petition for a writ of certiorari to review the judgment of the court of appeals, and the case was argued on November 10, 1987.

Thereafter, on December 22, 1987, the President signed into law the Omnibus Budget Reconciliation Act of 1987. Section 4106 of that Act provides that "[f]or purposes of

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Cong., 1st Sess. Pt. 1, at 484-485 (1987)) and the House Conference Report, as reproduced at 133 Cong. Rec. H12103, H12146, H12310 (daily ed. Dec. 21, 1987).

section 1903(f)(1)(B) of the Social Security Act, for payments made to California on or after July 1, 1983," the income level for a family consisting of two adults shall, at California's option, be the amount of AFDC payments that would ordinarily be made to a family consisting of an adult and two children. HCFA has concluded that the special provisions of Section 4106 of the Omnibus Budget Reconciliation Act of 1987, which apply only to adult couples in California, require that SPA 83-14 be approved, effective July 1, 1983, without regard to whether such approval was permitted by the general provisions of Section 1903(f)(1)(B)(i) of the Social Security Act, as the Ninth Circuit held in this case. Accordingly, by letter dated February 10, 1988, the Associate Regional Administrator of HCFA notified the Deputy Director of the California Department of Health Services that SPA 83-14 has been approved on the basis of Section 4106 of the 1987 Act, with an effective date of July 1, 1983. App. B, *infra*, 2a-4a.[2]

2. This case is presently moot as a result of the enactment of Section 4106 of the Omnibus Budget Reconciliation Act of 1987 and the February 10, 1988, letter from the Associate Regional Administrator of HCFA that approves SPA 83-14 pursuant to Section 4106, with an effective date of July 1, 1983. In light of HCFA's February 10, 1988, decision, which renders SPA 83-14 valid for the entire period

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[2] The Associate Regional Administrator of HCFA previously had informed the California Department of Health Services, by letter dated December 9, 1986, that SPA 83-14 was approved with an effective date of July 1, 1983. See App. C, *infra*, 5a-6a. But that letter made clear that HCFA's approval was given only conditionally, pursuant to the court of appeals' mandate (which had not been stayed), and that if this Court were to reverse the Ninth Circuit's judgment, HCFA's approval of SPA 83-14 would be void ab initio (*ibid.*). HCFA's February 10, 1988, letter approving SPA 83-14 expressly supersedes the conditional approval given by the December 9, 1986, letter. See App. B, *infra*, 3a.

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for which California has sought to have it approved, there is at this time no case or controversy in this Court regarding the correctness of HCFA's January 30, 1985, decision disapproving SPA 83-14 under Section 1903(f)(1)(B)(i) of the Social Security Act. The Court's "established practice" when a case that is pending before the Court for decision becomes moot is to vacate the judgment below and to remand with directions to dismiss the case as moot. *United States* v. *Munsingwear, Inc.*, 340 U.S. 36, 39-40 (1950). See, *e.g.*, *Deakins* v. *Monaghan*, No. 86-890 (Jan. 12, 1988), slip op. 5-8, 11; *Burke* v. *Barnes*, No. 85-781 (Jan. 14, 1987); *United States Department of State* v. *Washington Post Co.*, 464 U.S. 979 (1983).[3] The

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[3] The validity of SPA 83-14 has been the only underlying issue in this case from the outset: respondent Kizer's predecessor sought judicial review in the Ninth Circuit of HCFA's January 30, 1985, decision disapproving SPA 83-14, and the opinion and judgment of the court of appeals simply reversed the Secretary's decision disapproving SPA 83-14 (Pet. App. 19a, 21a). The court of appeals of course addressed several legal issues bearing on the validity of SPA 83-14 that went beyond the question whether SPA 83-14 was consistent with Section 1903(f)(1)(B)(i) of the Social Security Act—*e.g.*, whether a provision in an unpublished and since-rescinded 1979 regional office manual that lent support to California's position was a binding "legislative rule" for purposes of the Administrative Procedure Act (APA), and whether the "moratorium" provisions of Section 2373(c) of the Deficit Reduction Act of 1984 (DEFRA), Pub. L. No. 98-369, 98 Stat. 1112, barred the Secretary from disapproving SPA 83-14. However, the courts' rulings on those legal issues were simply *reasons* it advanced for why the Secretary's January 30, 1985, decision disapproving SPA 83-14 was erroneous; the correctness of that decision has at all times been the single underlying legal issue before the court of appeals and this Court.

Although HCFA has approved SPA 83-14, it nevertheless is important that the judgment of the court of appeals be vacated. That course would eliminate any precedential effect in other contexts of the court of appeals' ruling on the APA and "DEFRA moratorium" issues, as well as the precedential effect for States other than California of the court of appeals' holding that Section 1903(f)(1)(B)(i), standing alone,

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intervenor-respondents in this case (Barrier, Bierman and Kwiek) agree that this case is now moot, and they accordingly filed a Motion to Dismiss as Moot on January 12, 1988.[4]

Although this case is presently moot by virtue of the enactment of Section 4106 of the Omnibus Reconciliation Act of 1987, we have been informed by the Director of the Office of Management and Budget, by letter dated February 2, 1988, that the President intends to urge Congress to repeal Section 4106 as part of a larger package of proposed amendments to the 1987 Act. App. D, *infra*, 7a. The Director states that this legislative proposal "will be transmitted to Congress in the very near future for its prompt consideration" (*ibid.*). If Congress were to act promptly to repeal Section 4106, then this case would be restored to the same posture it was in when it was briefed and argued, as if there had been no intervening legislation. However, there can of course be no assurance that Congress will take any such action in the near future, and under the law as it currently stands, the case is moot. We shall inform the Court of the formal submission to Congress of the President's proposal to repeal Section 4106 and of any action taken by Congress on that proposal.[5]

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permits a family consisting of *two* persons to be regarded as the "same size" as an AFDC family consisting of *three* persons.

[4] The intervenor-respondents do not expressly state in their Motion to Dismiss as Moot that the judgment of the court of appeals should be vacated. However, in the decisions of this Court that the intervenor-respondents cite (at 3) for the proposition that this case should be dismissed, the Court vacated the judgment of the lower court. See *Hall* v. *Beale*, 396 U.S. 45, 49-50 (1969); *Diffenderfer* v. *Central Baptist Church*, 404 U.S. 412, 414-415 (1972).

[5] The February 10, 1988, letter from the Associate Regional Administrator of HCFA informs the Deputy Director of the California Department of Health Services that if Congress does repeal Section 4106 of the 1987 Act, HCFA's approval of SB 83-14 pursuant to Section 4106 would be void ab initio (App. D, *infra*, 4a).

CONCLUSION

If Section 4106 of the Omnibus Budget Reconciliation Act of 1987 is not repealed before the Court chooses to dispose of this case, the judgment of the court of appeals should be vacated and the case should be remanded to the court of appeals with directions to dismiss as moot the petition for review of the January 30, 1985, decision of the Administrator of the Health Care Financing Administration.

Respectfully submitted.

CHARLES FRIED
Solicitor General

FEBRUARY 1988

APPENDIX A

Section 4106 of the Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203 (Dec. 22, 1987), provides:

Medically Needy Income Levels For Certain 2-Member Couples in California.

For purposes of section 1903(f)(1)(B) of the Social Security Act, for payments made to California on or after July 1, 1983, in the case of a family consisting only of two individuals both of whom are adults and at least one of whom is aged, blind, or disabled, the "highest amount which would ordinarily be paid to a family of the same size" under the State's plan approved under part A of title IV of such Act shall, at California's option, be the amount determined by the State agency to be the amount of the aid which would ordinarily be payable under such plan to a family which consists of one adult and two children and which is without any income or resources. Section 1902(a)(10)(C)(i)(III) of the Social Security Act shall not prevent California from establishing (under the previous sentence) an applicable income limitation for families described in that sentence which is greater than the income limitation applicable to other families, if California has an applicable income limitation under section 1903(f) of such Act which is equal to the maximum applicable income limitation permitted consistent with paragraph (1)(B) of such section for families other than those described in the previous sentence.

APPENDIX B

Health Care
Financing Administration

DEPARTMENT OF HEALTH & HUMAN SERVICES

Region IX
100 Van Ness Avenue
San Francisco CA 94102

John Rodriguez, Deputy Director
Medical Care Services
Department of Health Services
714 P Street
Sacramento, California 95814

FEB 10, 1988

Dear Mr. Rodriguez:

On December 9, 1986 we advised you by letter that pursuant to the Court of Appeals' mandate in *Cubanski* v. *Heckler*, California State Plan Amendment No. 83-14 was approved with an effective date of July 1, 1983. However, we also noted that in the event the Department petitioned the United States Supreme Court for a writ of certiorari and the decision of the Court of Appeals were reversed by the Supreme Court we would view our approval of the amendment to be *void ab initio*. As you are aware, the United States sought Supreme Court review of the *Cubanski* decision and the Court agreed to hear the case, *sub nom. Bowen* v. *Kizer*, No. 86-863 argued November 10, 1987.

On December 22, 1987 the President signed into law the Omnibus Budget Reconciliation Act of 1987 (OBRA '87), Pub. L. No. 100-203. Section 4106 of that enactment provides that

> For purposes of section 1903(f)(1)(B) of the Social Security Act, for payments made to California on or

after July 1, 1983, in the case of a family consisting only of two individuals both of whom are adults and at least one of whom is aged, blind, or disabled, the "highest amount which would ordinarily be paid to a family of the same size" under the State's plan approved under part A of title IV of such Act shall, at California's option, be the amount determined by the State agency to be the amount of the aid which would ordinarily be payable under such plan to a family which consists of one adult and two children and which is without any income or resources. Section 1902(a)(10)(C)(i)(III) of the Social Security Act shall not prevent California from establishing (under the previous sentence) an applicable income limitation for families described in that sentence which is greater than the income limitation applicable to other families, if California has an applicable income limitation under section 1903(f) of such Act which is equal to the maximum applicable income limitation permitted consistent with paragraph (1)(B) of such section for families other than those described in the previous sentence.

Since under § 4106 of OBRA '87 California's amendment 83-14 clearly comports with the income limitation specified in § 1903(f) of the Act, the basis for our original disapproval of that amendment is no longer relevant. Therefore, we are now approving the amendment, with an effective date of July 1, 1983, on the basis of § 4106. This letter replaces our letter of December 9, 1986.

The enactment of § 4106 of OBRA '87 also removes the basis for our disapproval of California State Plan Amendments Nos. 84-20, 85-11, and 86-7 with respect to which you have sought reconsideration of the disapproval.

Accordingly, we are approving amendments 84-20, 85-11, and 86-7 with effective dates of July 1, 1984, July 1, 1985, and July 1, 1986 respectively.

We do wish to inform you, however, that we have been informed by the Director of the Office of Management and Budget that the President intends to urge Congress to repeal § 4106 of OBRA '87 as part of a larger package of proposed amendments to that Act. Since the approval of the four amendments at issue here is based solely on § 4106 of the 1987 Act, this approval will be void *ab initio* if Congress repeals § 4106.

Sincerely,

/s/ John L. O'Hara, Jr.

JOHN L. O'HARA, JR.
Associate Regional Administrator
Division of Program Operations

cc: Joe Stein, Esq.

APPENDIX C

Health Care Financing Administration

DEPARTMENT OF HEALTH & HUMAN SERVICES

Region IX
100 Van Ness Avenue
San Francisco CA 94102

John Rodriguez, Deputy Director
Medical Care Services
Department of Health Services
714 P Street
Sacramento, California 95814

DEC 9 1986

Dear Mr. Rodriguez:

We are in receipt of the attached mandate to implement from the U.S. Ninth Circuit Court of Appeals regarding the *Cubanski v. Heckler* decision of July 23, 1986. This letter is to advise you that, pursuant to the Court of Appeals' mandate, California State Plan Amendment #83-14 is approved with an effective date of July 1, 1983.

Please be advised, however, that this approval is made solely under the authority of the Court's order. In the event that the Department petitions the United States Supreme Court for a writ of certiorari in *Cubanski v. Heckler* and should the decision of the Court of Appeals ultimately be reversed by the Supereme Court, it is our view that the approval of SPA #83-14 would be *void ab initio*.

We shall keep you apprised of our decision regarding whether to petition the Supreme Court for a writ of cer-

tiorari. If you have questions, please call Bruce Campbell, California State Representative at (415) 556-4060.

Sincerely,

/s/ John L. O'Hara, Jr.

JOHN L. O'HARA, JR.
Associate Regional Administrator
Division of Program Operations

Attachments

cc: Frank Martucci, Chief
Medi-Cal Eligibility Policy
Cade Morrow, OGC, Region IX

APPENDIX D

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

FEB 2, 1988

Honorable Charles Fried
Solicitor General
Department of Justice
Washington, D.C. 20530

Dear Mr. Fried:

I understand that section 4106 of the Omnibus Reconciliation Act of 1987, Public Law 100-203, has some bearing on a case entitled *Bowen v. Kizer*, No. 86-863, currently pending before the Supreme Court.

This letter is to advise you that the President intends to urge the Congress to repeal this provision as part of a larger package of objectionable provisions contained in that Act. It is anticipated that this legislative proposal will be transmitted to Congress in the very near future for its prompt consideration.

You may wish to advise the Supreme Court of this in its consideration of a motion to dismiss as moot.

Sincerely yours,

/s/ James C. Miller, III

JAMES C. MILLER, III
Director

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